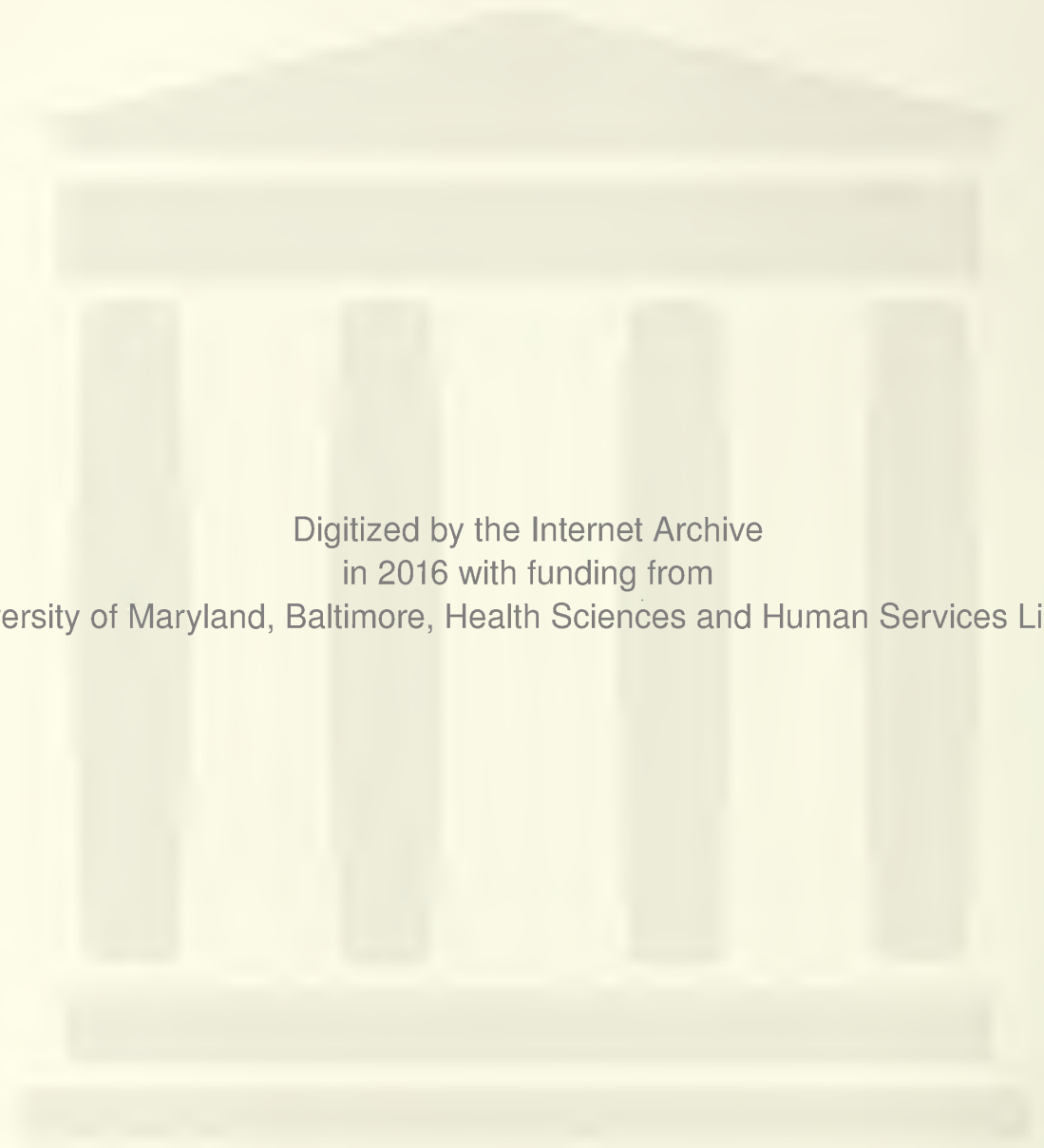


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Iowa Medicine
JOURNAL OF THE IOWA MEDICAL SOCIETY | JANUARY 1997

STACKS



Can you afford to ignore the Internet?

This question and many more are answered in the center insert

STACKS

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FEB 6 1997

The "New Guy" hits the ground running

See page 20 for a special Q & A with Michael Abrams, IMS executive vice president

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IN THE NEWS

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IMS plans survey of practicing physicians 10

New laws affecting Iowa physicians 12

A Des Moines attorney discusses the Anti-Kickback Law and what it means for Iowa physicians

See page 23

STACKS

1997 Iowa Legislature convenes January 13

See page 13 for IMS legislative priorities

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IMS *DEADLINE* news

January, 1997

Late-breaking news of interest to Iowa physicians

●**PHYSICIAN OFFICES IN IOWA** are being inundated with calls from patients as the effective date of Iowa's new handicapped parking law approaches. Physician offices should inform patients who need handicapped parking permits that they have until January 1, 1998 to get the new permits. Even though it officially goes into effect January 1, 1997, the new law provides a one-year phase in of the new permits. For more information on the new requirements, see page 12 of this issue of *Iowa Medicine* or check the IMS web site at http://www.IowaMedicalSociety.org.

●**AS OF PRESS TIME,** several organizations had filed a lawsuit to delay implementation of the new parental notification of abortion law, which is scheduled to go into effect January 1, 1997. The law will affect any physician who provides pregnancy-related services to a pregnant minor, whether or not an abortion is contemplated. The lawsuit claims the law is unconstitutionally vague and will violate the rights of the pregnant minor. A hearing is scheduled for January 2 and a decision on the request for a temporary delay in implementation of the law is expected within a few days. IMS members will be notified of the results of this hearing. See page 12 of this *Iowa Medicine* for more information on the law.

●**THE IOWA FOUNDATION FOR MEDICAL CARE** (IFMC) recently approved a plan for restructuring. The new plan — approved unanimously - decreases the number of directors from 40 to 18 while continuing representation for all Iowa physician members. Ten of the 18 positions are to be held by Iowa IFMC physician members, a voting majority. A letter detailing all bylaw amendments was recently sent to all IFMC physician members. The amendments will go into effect unless petitions signed by at least 10% of the members of record are received requesting a full membership vote.

●**THE IMS WEB SITE** is up and running at http://www.IowaMedicalSociety.org. See the enclosed insert for details on the IMS site and the Internet in general. Access to certain portions of the web site is a benefit of membership in the IMS. Therefore, in order to access certain sections of the IMS web site, you will need a password. IMS member physicians may call Melanie Finke or Laura Nelson at the IMS to get a permanent password. Don't miss our "New on the Net" column (page 7), which will be a regular feature in *Iowa Medicine* starting this month.

●**YOU WILL SOON BE RECEIVING** a survey of Iowa physicians being conducted by the Iowa Medical Society. The survey, which will be sent to both IMS members and nonmembers, seeks information about your practice, your concerns and your needs. Results of the survey will help IMS determine the direction of future programs and services. Please fill out the survey and drop it in the mailbox by January 22. Thanks for your help!

●**THE IOWA MEDICAL SOCIETY'S FIRST VENTURE** into educational programming via the Iowa Communications Network was well-received and well-attended. Close to 400 physicians and office managers attended the December 11 program: "When Bad Things Happen to Good People: Why You Need a Billing Compliance Program". Based on feedback from participants, the IMS will provide additional information on developing a billing compliance program. Other specific questions will also be addressed in future issues of *Iowa Medicine* and in the IMS web site.

For more information about any *DEADLINE* news item, call Chris McMahon at IMS headquarters, 515/223-1401 or 800/747-3070.

Iowa Medicine

JOURNAL OF THE IOWA MEDICAL SOCIETY JANUARY 1997 / VOLUME 87 / 1

You won't want to miss the 1997 IMS Scientific Session & Annual Meeting. This revamped April 18-20 weekend will include hands-on Internet training, a Q & A on the virtual hospital, featured speakers on technological advances in medicine and clinical controversies. Call the IMS or send an e-mail message to Cheri Jensen at admin@netins.net to register.

About the Cover

When you see the logo on this month's cover, you'll know you're in the IMS web site which premiered November 11. Check it out at www.IowaMedicalSociety.org.

Editorial Board

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FEATURE ARTICLES

Follow the leaders 5

It's time to call on our best navigators to chart the Iowa Medical Society's course in the future.

New on the Net 7

This column will keep you up to date on how to make the Internet work for you and your practice and what's new on the IMS web site.

Managed Care . . . News you can use 9

Mercy Clinic in Des Moines offers many advantages to physicians (sixth in a series).

Current Issues 10

Survey of Iowa physicians, *p. 10* . . . New laws affecting physicians, *p. 12* . . . Iowa is test site for Medicare claim edit software, *p. 14* . . . Alteration of medical records, *p. 17*

EVP Abrams: "I immediately felt comfortable with the medical society" 20

Strategic planning and membership retention and recruitment will be top priorities for the Iowa Medical Society's new executive vice president. *MICHAEL ABRAMS*

Anti-Kickback Statute: Combatting fraud and abuse 23

The author, a member of a Des Moines law firm, explains what's prohibited under the Federal Health Care Program Anti-Kickback Act. *WILLARD BOYD III*

Current therapy of Parkinson's disease 27

Part 1 of a two-part article on treating early mild and moderately advanced Parkinson's disease. *TODD AJAX, MD; ROBERT RODNITZKY, MD; JUDITH DOBSON, RN*

Drug-seeking patients 31

A busy family practitioner found a way to handle patients who frequently request drugs. *STEPHEN ECKSTAT, DO*

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Your blueprint to financial independence *JERRY FOSTER* 25

Numerous physicians made their mark *MARION ALBERTS, MD* 33

The ethics of selling snake oil *RICHARD CAPLAN, MD* 35

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Follow the leaders

Our health care system is being put to the test. Society is demanding cheaper, more "successful" means of delivering care. Technical advances coupled with problems such as drug resistant TB and drug use by teenagers challenge the most carefully crafted professional guidelines. Methods of compensation under managed care may destroy traditional incentives and certainly test our ethics.

Is it enough for physicians to fall back on venerable answers such as "do no harm, patient confidentiality and patient welfare above self"? I believe we need the collective wisdom of our profession to plot a course true to the core values that elevate our calling. I think it is time to call upon our best navigators to chart that course. In sailing we know the best way to find the next mark is to follow the leader, but who is that?

I believe that each of us has met that leader and "It is us". With the right tools, enough time and a kind of compassionate tenacity, any of our 4,000 member physicians could be the leader we would trust and follow. If you feel you laek leadership potential, you can help by simply lending your perspective when the IMS determines its future direction.

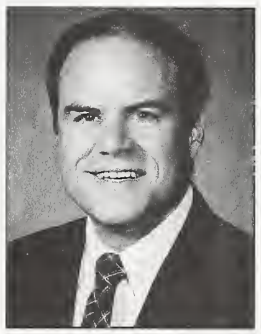
When I first entered medical politics I hoped to make a difference, maybe right some wrongs. I learned that my straightforward answers sometimes got lost in the process and politics. I also learned, however, that a defeated issue or lost election teach the realities of our system and provide experience to judge the right way to initiate successful change.

But you have to be there to succeed. The rewards of participation in IMS leadership are many. You are part of a group of physicians who get a unique perspective on today's health care issues, you serve your profession and you have the opportunity to meet colleagues from across the country. You gain influence in your community and the respect of your peers and your family.

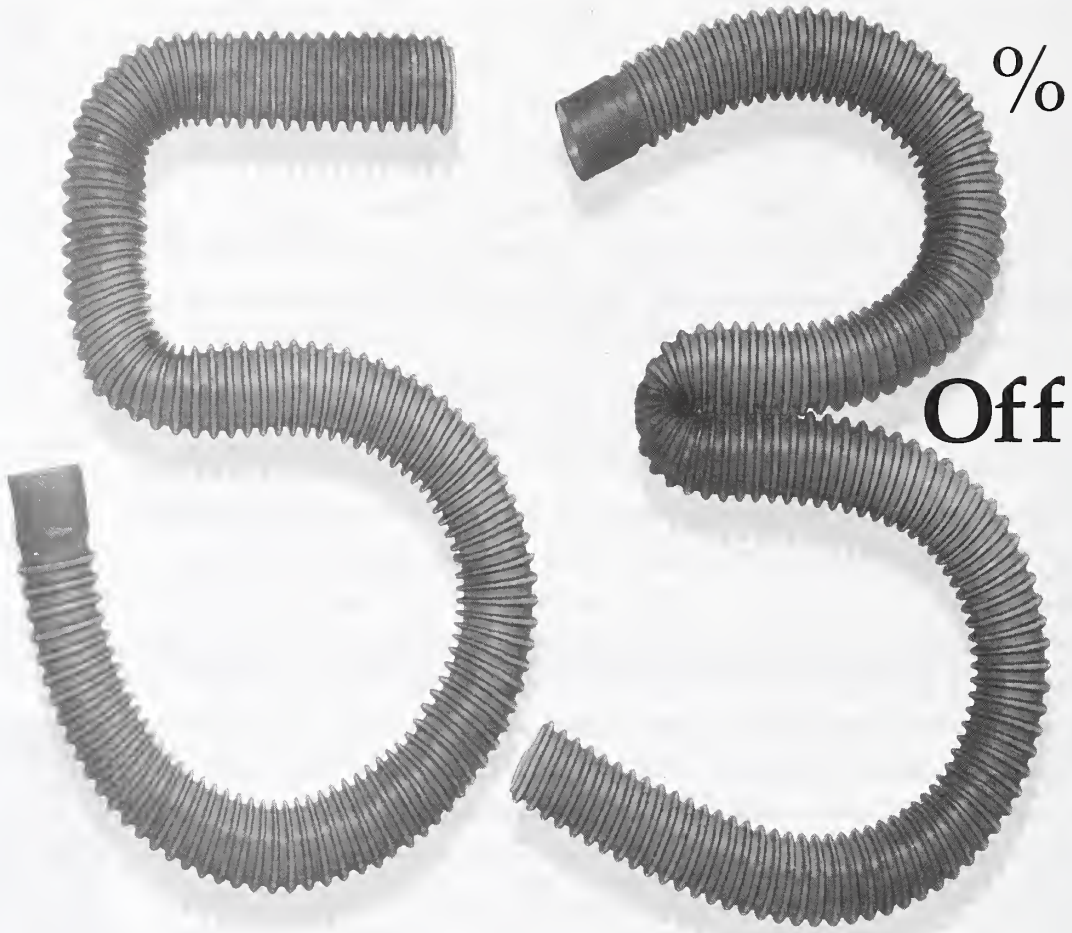
The bottom line is, the Iowa Medical Society needs you. To that end, we pledge to supply knowledge of the issues, communications training, exceptional staff support and fair elections.

I believe we need the collective wisdom of our profession to plot a course true to the core values that elevate our calling.

Remember, all politics is local, so I encourage those who want to make a difference to attend your IMS caucus. (A list of caucuses can be found on page 11.) Help define the issues. If the IMS needs to head in a different direction, jump in and lead the way. There is not a finer organization to represent or be represented by. Our job is to keep it that way. Ignore this valuable opportunity and very likely politics, economics and lawyers will decide our future for us. IM

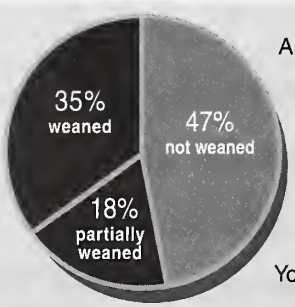


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New on the Net

Make the Internet work for your practice

You're probably tired of hearing about the Internet. Unless you've been hiding for the past six months, you know the the Internet is making its mark as the newest medium of communication. Everyone seems to be praising its vast resources.

The Internet is far from perfect, though. Crossed signals and slow downloading times can make novices and experts alike click out of cyberspace in despair. Sifting through the immense amount of information on the Internet is in itself frustrating.

Don't give up yet. Recognize the Internet's great resources as well as its limitations. You'll find the Internet will become a tool in running your practice. It might just take a little time and you may need a little help.

The IMS web site is a good starting point for learning how the Internet can help you in your practice. Besides news clips and an e-mail directory of IMS staff, you'll find practice management advice including a practice management question of the week and Medicare E&M utilization data on the IMS web site.

The IMS web site also has a links section that can catapault you to other sites on the World Wide Web, cutting down on the time you dedicate to surfing.

Consult the University of Iowa's Virtual Hospital for help diagnosing a tough case. Earn that last CME hour online by checking the CME Search site for online education opportunities. Research a drug before prescribing it at Medsite Navigator's drug directory. Order the latest Medicare regulations from the Government Printing Offiee.

IMS is ready to help you make the Internet work for you and your practice. Feel free to contact Melanie Finke at the IMS by e-mail at communic@netins.net or by phone at 800/747-3070 if you have Internet questions or want to know how to get a special member password for the IMS web site.



Linking IMS physicians to the information they need

Hot sites

Links: Check out the IMS web site's links section for a quick gateway to medical information on the Internet. Sites are organized in such categories as medical information gateways and reference sites, medical associations, health organizations and condition-related organizations.
http://www.iowamedicalsociety.org

Great gateway site: Medsite Navigator offers news alerts, a directory to journals and a reference guide to drug information all on one site. *http://www.medsitenavigator.com*

News: *Reuters Medical News* is on the Internet with daily news capsules about national clinical, managed care and legislative news. You'll have to register for a password. *http://www.reutershealth.com/news*

Brain atlas: Physicians at the AMA's Interim Meeting in Atlanta were enthralled with The Whole Brain Atlas, a site that shows scans of the brain suffering with different diseases. *http://www.med.harvard.edu:80/AANLIB/home.html*

Patient education: Show patients how diseases attack their bodies with Cells Alive! Images on the site illustrate how such cells as E. coli and HIV attack the human body. *http://www.comet.chv.va.us/quill* IM

IMS staff members are on the watch for sites that might interest Iowa physicians. Staff members visit all Hot sites *to make sure they have useful information and reasonable download times. Suggestions for* Hot sites *can be sent to Melanie Finke by e-mail at communic@netins.net or by telephone at 800/747-3070.*

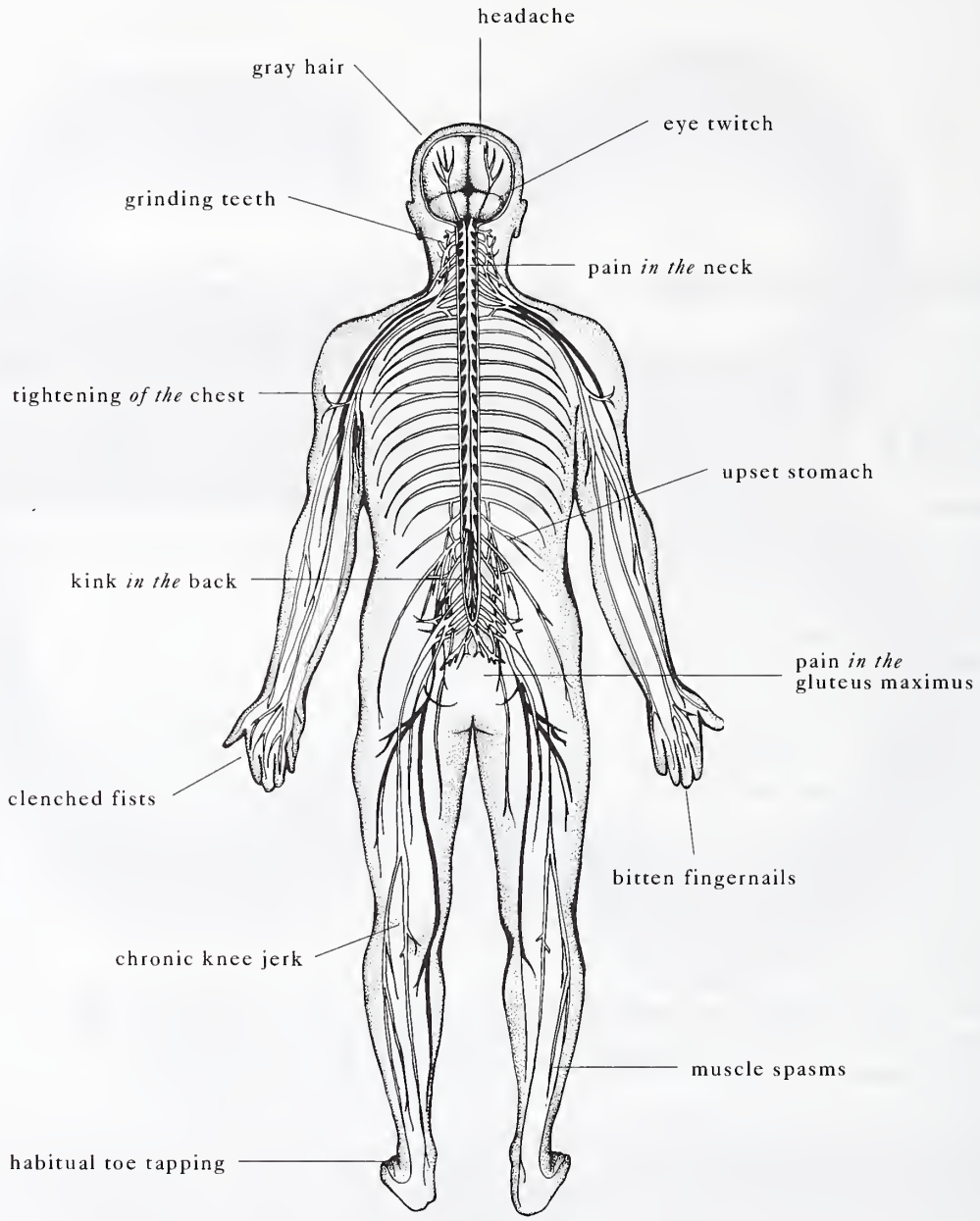


Figure 23

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Mercy Clinic offers many advantages to physicians

(Sixth in a series)

Mercy Clinic, a broad-based Des Moines eorporation which offers both clinical and educational serviees, opened its doors in 1983. Today the Mercy Clinic system includes 18 sites, 100 physicians, 700 employees, 150,000 regular patients and 500,000 outpatient visits yearly.

Physician-governed, multispecialty group

"With changes in health care, physicians were the last ones to get themselves organized. Insuranee companies, government entities and hospitals were vying for control, but none of them were as close to patients as physieians were," explains Dr. Stephen Gleason, CEO and chief medical officer of Mercy Clinic. After several proposals, a group of physicians went into partnership with Mercy Hospital and created a new corporation independent of the hospital.

Dr. Gleason describes Mercy Clinic as a foundation model, physician-governed, multispecialty group with a strong primary care base. The elinie is modeled after Mayo Clinic with a board of five physician directors and several representatives from the community and Mercy Hospital. The centerpiece of the organization is the seven-member Physician Practice Advisory Committee. According to Dr. Gleason, most key decisions are made by this committee and the management team.

Many advantages for physicians

"I think a physician-driven or governed system is important to maintain a patient-centered perspective," comments Dr. Gleason. "What makes Mercy Clinic unique is that physician members of our board of directors are eleeted to offiee, not appointed. Our physicians have a chance to participate in management and governance if they so choose by running for office and voting for board members."

There are other advantages for physicians in this type of structure. Within Mercy Clinic, physicians can take an active role in education and research. In the last three years, staff raised $8.3 million for clinic research funding. In addition, a new program in partnership with the Mayo Medical School just began which includes a residency program and research.

Another advantage to organizing this type of group is the ability to finance a support staff that pays attention to changes in regulations, the legal environment and accounting rules.

Continued growth is goal for the future

"We've added 40 physicians in the last three years. We'd like to expand our primary and specialty care in rural Iowa," remarks Dr. Gleason. Currently Mercy Clinic has sites in urban, suburban, rural and inner city areas. Eleven specialty areas are represented and a medical ethicist is on staff also.

Advice for Iowa colleagues

Dr. Gleason offers several tips for physicians contemplating organizing. "There is some safety in numbers and some economies of scale when physicians collaborate. Don't get upset with colleagues trying creative ventures; someday they may be your partner. Don't sell out for cash—participating in governance and policy-making is more important in the long run. Look at the organizational structure of the group you may collaborate with. Can you participate in some capacity in determining the future course of the organization?"

Dr. Gleason concludes, "Aside from identifying good partners, practicing good medicine and being nice to patients is still the best thing one can do." IM

"Don't get upset with colleagues trying creative ventures; someday they may be your partner."

KEY CONTACTS:

Mercy Clinic
515/248-4515

Stephen Gleason, DO
CEO/chief medical officer

Dave Sweiskowski, MD
Assistant chief medical officer

James Caterine, MD
Chief of specialty services

Linda Salomone
Senior vice president for operations

If you know of other innovative practice arrangements — especially those controlled by physicians and positioned to compete in the managed care market — call Barb Cannon or Chris McMahon at the IMS, 515/223-1401 or 800/747-3070.

IMS Update

News at a glance

Dr. Clarence Denser, Jr., MD has been elected president-elect of the North Central Medical Conference. Dr. Denser, a Des Moines pathologist, is a member of the IMS delegation to the American Medical Association. He will take office as NCMC president in November of 1997.

Nominations are being accepted for the 1997 Outstanding Iowa Medical Office Administrator Award. The recipient will be chosen by a committee of Iowa Medical Group Management Association members and will be honored at the IMS Annual Meeting. To nominate a clinic manager, contact Dana Petrowsky at IMS Services, 515/223-2816 or 800/728-5398.

Survey of Iowa physicians

This month, the Iowa Medical Society will be asking Iowa physicians about their concerns, their priorities and what the IMS can do to help.

As part of a comprehensive strategic planning process, the IMS will survey all practicing physicians. The survey will be the first tool used by IMS leadership to determine the future direction of the organization.

The survey contains very specific questions about issues which most concern Iowa physicians today and new services which IMS might offer to help members cope with the changes in health care delivery.

The focus of the survey is on issues which affect medical practice. IMS leadership urges all physicians to complete the survey and return it to IMS. The survey is being conducted by the IMS Board of Trustees with the assistance of Charlton Research Company.

If you want to know what issues are on the minds of your Iowa colleagues, check future issues of *Iowa Medicine* for survey results.

New IMS Directory on its way

Due to a computer problem in the member listing, a new 1997 IMS Directory has been published and will be sent to you very soon. The new directory will have the color red on the cover; the words "Revised Edition" will appear in the upper right hand corner. If your clinic ordered multiple copies of the old directory, you will receive the same number of new ones.

Members are asked to throw away the old directory as soon as the new one arrives. We apologize for any inconvenience the directory may have caused.

News from Iowa Medical Group Management Association (IMGMA)

A beneficial relationship

The relationship between the Iowa Medical Group Management Association and the Iowa Medical Society has been mutually beneficial. There are several reasons for this. The most obvious being that the business of medicine is the core of our existence. The second reason is that the executive director of the IMGMA, Dana Petrowsky, is also employed by the IMS and she is able to coordinate efforts between the IMGMA and IMS.

This working relationship has been amicable for both entities and further enhancement of the relationship is desired.

Taking this relationship one step further is the job of IMGMA's president, Nancy Park and the board of IMGMA. A collaborative agreement will soon be negotiated with the IMS.

For the IMGMA, the agreement will ensure coordination of practice management educational seminars and programs. The IMS will be able to offer various programs that are relevant for today's medical offices.

Fundamental to both IMGMA and IMS is the advocacy for legislative issues and other business topics of both organizations.

(This article was written by Nancy Park of Marshalltown Medical & Surgical Center.)

A journey into cyberspace

1997 IMS Scientific Session

A Journey into Cyberspace

A Journey into Cyberspace is the theme of the 1997 IMS Scientific Session, set for Friday, April 18 at the Embassy Suites Hotel, Des Moines. The meeting will feature presentations on technological advances in medicine, including telemedicine, electronic medical records and the University of Iowa's virtual hospital.

Managed care expert Jacque Sokolov, MD of Los Angeles will be Friday's keynote speaker. Watch next month's *Iowa Medicine* for an article by Dr. Sokolov.

Specialty Society Update

The Iowa Academy of Otolaryngology held its membership meeting following the Grand Rounds Clinical Conference at the University of Iowa on December 6, 1996. The meeting was attended by approximately 25 physicians. President Philip Lee and the members discussed issues from the recent membership survey of the IAO, formation of a semi-annual newsletter and appointing a representative for the IMS House of Delegates for April 1997.

For more information, contact Dana Petrowsky or Dave Furneaux at 515/223-2816 or 800/728-5398.

Focus on IMS Alliance

"Baby Think It Over"—What teens have to say

"Being a parent is a 24-hour-a-day job." (Tama)

"By the time I got back to sleep, I was waking up again. It's a big job." (Des Moines)

"Baby Think It Over is as close as you can get to caring for the real thing." (Boone)

"It didn't change my mind about having kids, but it did about having kids at an early age." (Des Moines)

"I'm so glad to get rid of this baby. I'm glad it's not real." (Oskaloosa)

Thanks to all the spirited IMSA members who have been instrumental in getting BTIO into the schools of their respective counties.

There are more educators requesting BTIO than we can fund. Help us meet the demand by purchasing a doll. Mail your check for $250 per doll to Sandy Nichols, IMSA, 1001 Grand Avenue, West Des Moines, Iowa 50265. Contributions are tax deductible.

Thanks for all you've done and continue to do to enhance the lives of Iowa citizens.

Nominees sought for physician award

The IMS is accepting nominations for its 1997 Physician Community Service Award, which honors an Iowa physician who has provided outstanding uncompensated civic, charitable and health services. To nominate a physician, contact Dean Gillaspey at IMS, 515/223-1401 or 800/7470-3070 by March 3. The award recipient will be honored at the IMS Annual Meeting April 19-20. IM

Iowa Medical Society 1997 District Caucuses

Dist.	Date	Location and Time	Councilor
1	2/12	Pzazz, Burlington, 6:30 pm	Robert Kent, MD
2	2/5	Highlander, Iowa City (after business mtg)	Jamal Hoballah, MD
3	1/22	Iowa Machine Shed Restaurant, Davenport 6 pm	Eugene Kerns, MD
4	2/11	Mercy Hosp Educ Ctr, Cedar Rapids, 8:30 pm	Steven Jacobs, MD
5	1/28	Knight Light Supper Club, Dyersville, 6 pm	Ross Madden, MD
6	1/14	Prime and Wine, Mason City, 6:30 pm	John Justin, MD
7	1/7	Covenant Medical Center, Waterloo, 7:30 pm	Steven Erickson, MD
8	1/8	The Cottage Restaurant, Story City, 6 pm	Leo Milleman, MD
9	2/4	Ottumwa Country Club, 6:30 pm	Jay Heitsman, MD
10/11	1/15	Des Moines Marriott, 5:30 pm	Michael Disbro, MD C. David Smith, MD
12		Contact IMS	John Fernandez, MD
13	1/13	Stewart Memorial Hosp, Lake City, 7 pm	Linda Iler, MD
14	1/28	Sister Sarah's Restaurant, Algona, 7 pm	Stephen Richards, DO
15	2/14	Sioux City Country Club, 6 pm	Kathryn Opheim, MD

Legislative Affairs

News at a glance

Responding to a surge of media criticism of HMOs that classify a mastectomy as an out-patient procedure, the American Association of Health Plans adopted a policy urging its 1,000 members not to deny physician and patient requests for hospital stays post-mastectomy. Some state and federal lawmakers are proposing legislation to mandate 48-hour hospital stays.

Changes to Iowa's handicapped parking law made by the Iowa Legislature in 1996 will be effective January 1, 1997. Under the changes, holders of permits will have to reapply for a new parking permit during 1997. A signed statement from a physician must accompany an application for a permit. Call Bev Corron at the IMS for a copy of the new requirement or check the IMS web site.

New laws affecting physicians

Pregnant minors

Physicians who provide pregnancy-related medical care to pregnant minors should be aware of a new law which went into effect January 1. The law requires physicians to offer the minor on the first visit, viewing of a video which is intended to assist the minor in making decisions relating to her pregnancy. The video and a manual will be provided at no cost to all family physicians, obstetricians and pediatricians in Iowa; they should arrive at your office in early January. Physicians who do not receive the materials should write to Carol Hinton, Family Services Bureau, Iowa Department of Public Health, Lucas State Office Building, Des Moines, IA 50319-0075.

The new law also requires that in most cases a parent must be notified prior to the minor receiving an abortion. Parental consent is not required. In a medical emergency a parent must be notified within 12 hours after the abortion is performed. Notification of the parent is not required in any of the following circumstances: a parent has submitted written authorization of the termination of the pregnancy, a court has authorized waiver of the notification requirement, the minor declares being a victim of child abuse by the parent which has been reported or founded or the minor declares being a victim of sexual abuse which has been reported.

The IMS provided detailed written comments which were incorporated into the final version of the administrative rules implementing this new law. For a copy of the parental notification rules call Cheryl Peers at the IMS or for more information call Becky Roorda.

Handicapped parking permits

Another new law physicians should be aware of makes several changes relating to handicapped parking permits. Beginning January 1, 1997 handicapped parking permits may only be issued to persons meeting at least one of the following criteria:

- Cannot walk 200 feet without resting;
- Cannot walk without an assistive device;
- Is restricted by lung disease such that the forced expiratory volume for one second is less than one liter or the arterial oxygen tension is less than 60mm/hg on room air at rest;
- Uses portable oxygen;
- Has a cardiac condition with functional limitation in class III or IV according to American Heart Association standards;
- Walking is severely limited due to an arthritic, neurological or orthopedic condition.

For temporary permits the physician's statement must state the period of time during which the person is expected to be handicapped and the period for which the permit should be issued, not to exceed six months. Temporary permits may be renewed.

The handicapped person is responsible for applying for the permit through the Department of Transportation driver license station and for obtaining and submitting the physician's statement. The physician's statement must be on letterhead.

A patient or physician who provides false

information with the intent to defraud in obtaining a permit may be fined $300.

1997 legislative agenda

The 1997 session of the Iowa legislature begins on Monday January 13. IMS priorities for the session were recommended by the Committee on Legislation and have been approved by the Board of Trustees.

Liability reform and managed care issues are the two top priorities for the IMS in 1997. With the change in leadership in the Senate, passage of needed liability reform seems more possible. The IMS will pursue a cap on noneconomic damages and a reduction in the long statute of limitations for minors (an IMS bill passed the House in 1995 but was not passed by the Senate).

In the arena of managed care, the IMS will work for legislation to require employers who provide health benefits to offer employees either a fee for service plan or point of service feature in a managed care plan. The point of service feature would allow the patient to go to physicians outside the provider network; the patient may have to pay a slightly higher premium, deductible or copayment based on the actuarial costs of the plan.

Many other issues are expected to come up as well. Scope of practice issues continue to be important as the health care delivery system evolves. Changes are being proposed to the Iowa Administrative Procedures Act which sets out the procedures used by the Board of Medical Examiners and other state agencies in the disciplinary process and other contested cases. The Act also lays out the process by which regulations are adopted by state agencies. The IMS will work to ensure due process for physicians and opportunities to affect the regulatory process.

There are many new legislators in 1997. The IMS will send out a legislative directory as soon as it is available. If you do not know the name of your state senator or representative, call Cheryl Peers at the IMS.

Good news on optometry lawsuit

A ruling has been issued on the motion for summary judgment in the lawsuit filed against the Iowa Academy of Ophthalmology (IAO) by the Iowa Optometric Association and nine optometrists.

The good news is that the judge upheld the IAO in all of the issues raised by the optometrists concerning the Board of Medical Examiners' declaratory ruling on postoperative care. The IAO has been totally absolved of any liability in those matters. However, the judge allowed the plaintiffs to keep a toehold in the case based on what he thought was a narrow "material issue of fact" which remains in dispute. According to the law, a summary judgment motion cannot be granted if there is room for controversy or disputed facts.

The remaining issue concerns a local conflict in Cedar Rapids. The IAO plans to be very aggressive in resolving the matter. IM

CONTACTING YOUR LEGISLATORS

Telephone numbers during the session:

Senators	**515/281-3371**
Representatives	**515/281-3221**
Governor	**515/281-5211**

Write to them at:
STATEHOUSE
Des Moines, Iowa 50319

You may also contact your legislators at home when the legislature is not in session. If you don't know who your legislator is or need your legislator's home address and phone number, call Cheryl Peers of the IMS staff, 800/747-3070 or 515/223-1401.

Medical Economics

News at a glance

Iowa's Medicare inpatient payments rank at nearly the bottom of the barrel — 48th out of 51 states. Iowa's average payment is $5,195; the Midwest average is $5,971 and the U.S. average is $6,769.

Insurance reforms in the Kennedy-Kassebaum bill were actually passed by the Iowa Legislature years ago, Iowa Insurance Commissioner Therese Vaughan told the IMS Board of Trustees at a November dinner meeting. Ms. Vaughan foresees no major legislative initiatives from the Iowa Division of Insurance beyond "tinkering" with Iowa law to bring it into compliance. Ms. Vaughan also told the Board that she is concerned about issues such as gag clauses which arise when certain managed care companies enter a state.

Iowa is test site for T.18 edit software

Iowa has been selected as the pilot test site for the Medicare test of the GMIS claim editing software. GMIS, an "off the shelf" commercial claim editing software package, is in wide use throughout the country by private payers and managed care companies. It has been suggested that using off the shelf type editing software will save the Medicare program millions of dollars annually from claim errors.

The Iowa test will not have any effect on actual claim payments. Rather the pilot will be a parallel test run for analysis only. The test is slotted to begin in April 1997 and most likely be completed with a report to HCFA in September 1997. If potential savings are documented in the Iowa test, the GMIS software may be implemented nationally by Medicare.

The GMIS software is a database that is used to review the logic and accuracy of physician billing. One component of the Iowa pilot is detailed review of the database to be sure it is consistent with existing national Medicare payment policy and that the software works in the Medicare claim processing environment.

Dr. John Kelly, chief medical officer of GMIS, in a telephone call to the IMS, said that "GMIS is looking forward to working with the IMS to assure this pilot is done in as fair, efficient and effective way as possible." He said he is pleased to be working with Iowa physicians and looks forward to their assistance in the pilot. GMIS is a Pennsylvania-based firm that was recently acquired by HBO and Company.

Dr. Kelly stated that since the pilot site is Iowa, IMS must know and understand what GMIS is doing. They look forward to an exchange of information both on the process and on the pilot findings. More information will be reported in *Iowa Medicine* as it becomes available.

IMS joins attorney general tobacco suit

The Iowa Medical Society is participating in a lawsuit brought by Iowa Attorney General Tom Miller against the tobacco companies. The suit, like those being brought in other states, seeks to recover Medicaid funds used to treat smoking-related illnesses.

In late November, members of the IMS Board of Trustees participated in press conferences around Iowa announcing the filing of the lawsuit. Remarks made at the Des Moines press conference by Dr. William McMillan were replayed on several radio stations.

Big changes at Blues

Blue Cross Blue Shield is undergoing "radical reform" under John Forsyth, the new chief executive officer, said a recent *Des Moines Register* article. Forsyth's goals are reducing administrative expenses, eliminating corporate hierarchy and focusing on public health issues.

The IMS Board of Trustees will meet with Mr. Forsyth January 15; he will address the IMS Executive Council January 16. IM

DATA & TECHNOLOGY

Physician profiles now available through IMS

The Iowa Medical Society is pleased to announce the signing of a contract with QuadraMed Corporation for the exclusive use of their QuanTIM Clinical Performance Measurement software. The software and an all-payer, all-patient data base allows IMS to help physicians analyze their own performance data.

Organizations such as insurance companies, managed care organizations, hospitals and other health care providers are using various data bases to "rate" physicians. However, these organizations usually have access to a limited data base, or do not risk adjust the data prior to analysis.

IMS and QuadraMed have purchased an inpatient data base which will reside at IMS along with the software. This gives the IMS a tool to help physicians analyze their own data in an educational rather than punitive environment. Other data bases will be purchased as they become available to help you analyze data trends.

The QuanTIM Clinical Performance Measurement software allows a physician to compare his or her inpatient outcomes to other physicians across the state or within a specific specialty for self-assessment or quality improvement. The all-payer, all-patient data base gives a more complete analysis than is possible by external organizations. Most importantly, the software utilizes a risk adjustment technique to account for the fact that different patients with the same diagnosis may have pertinent, risk increasing conditions or characteristics that impact the probability of having a particular outcome. Risk adjustment is absolutely necessary before performance data can be analyzed.

Physicians will order reports directly from the IMS. The first report and graph will display your data compared to other Iowa physicians on a broad scale at a cost of $250. Included is a comprehensive interpretation to tell you what the numbers and graphs mean. You may purchase other reports to chart your data in virtually unlimited combinations. This is valuable if you are classified as an "outlier" (high or low) or if you are simply curious. The software gives you the ability to look at data in significant detail—to individual patient level data if necessary.

Physicians may choose inpatient clinical outcomes covering six major analysis categories: 1) general; 2) cardiac; 3) obstetrics; 4) neonatology; 5) surgery; 6) mortality. Additionally, there are 103 specific outcome topics within these six categories, e.g., postoperative infection, c-section, VBAC, CABG mortality, MI mortality, etc.

It is imperative that you become aware of how you are being rated by other organizations. This service can help you:

- Understand how data can be utilized to your advantage;
- Prepare more accurate and comprehensive analyses of your patterns;
- Utilize the data to market your areas of excellence;
- Realize why your outcomes may be different than your peers;
- Determine changes you can implement so the numbers will cast you in a better light.

For more information, contact Ed Whitver at the IMS, 515/223-1401 or 800/747-3070. You can also see examples of reports and graphs on the IMS web site at www.IowaMedicalSociety.org. IM

For more information, call Ed Whitver, IMS manager of health care data and technology, 515/223-1401 or 800/747-3070.

Practice Management

News at a glance

At a recent state meeting of the Society for Human Resources Management, a Davenport law firm had excellent recommendations regarding workplace use of e-mail and Internet. Lawyers cautioned that postings of reimbursement rates, salary information, etc. on the Internet could have antitrust implications. Employees should be warned that threats, harrassment, pornography or obscenity violations when using this technology are subject to discipline or termination. For copies of suggested office policy on voice mail and e-mail, contact Dave Furneaux at IMS Services, 515/223-2816 or 800/728-5398.

Practice analysis software available

A helpful service for physician offices is being offered by the Center for Research in Ambulatory Health Care Administration (CRAHCA), a subsidiary of the Medical Group Management Association. CRAHCA has developed software called "Physician Services Practice Analysis" (PSPA).

PSPA is a comprehensive, responsive software designed by and for practices whose physicians understand the need to analyze performance compared with other practices and to project future performance.

PSPA uses key practice management variables and the Resource-Based Relative Value Scale to analyze productivity and conduct cost accounting and payer analysis.

PSPA software can be purchased from CRAHCA for $925 (MGMA member price). It can be loaded into your computer. Your data is periodically submitted to CRAHCA, where it is merged with data from other practices across the country.

You will receive reports comparing your practice and other practices. You can use the software to help set charges for services, develop physician compensation programs, negotiate and analyze payer contracts and many other functions. You can even use PSPA to compute Per Member Per Month premiums needed to make capitation profitable.

For more information, contact Ed Whitver at IMS by phone (800/747-3070) or e-mail (www.iowamedicalsociety.org).

Outstanding office administrator award

IMS is accepting nominations for its annual Iowa Medical Office Administrator Award. The recipient of the award will be chosen by a committee of Iowa Medical Group Management Association members and will be honored at the IMS Annual Meeting.

To nominate a clinic administrator, call Dana Petrowsky at IMS Services, 515/223-2816 or 800/728-5398. IM

Practice Management Workshops for You

How To Collect for Control

February 19	**North Iowa Mercy Medical Center, Mason City**
February 20	**Allen College, Waterloo**
February 21	**St. Ambrose, Davenport**

An advanced training seminar designed to improve your success in preventing and collecting medical account receivables. Seminar times are 9:00 a.m. – 4:00 p.m. Instructor: Jeff Staads, Business Resource Center.

1997 CPT Update

January 21	**Trinity Rgional Hospital, Fort Dodge, 6 – 8:30 p.m.**
January 23	**Marshalltown Medical & Surgical Center, Marshalltown, 11:00 a.m. – 1:30 p.m.**

An overview of new 1997 CPT codes and changes in existing codes. Instructor: Barbara Cannon.

For more information or to register for any IMS practice management workshop, call Sherry Johnson at IMS Services, 515/223-2816 or 800/728-5398.

Midwest Medical Insurance Company Focus on Risk Management

Alteration of Medical Records

A patient saw her physician with complaints of pain and swelling of her ankle five days after a fall. The physician diagnosed a fracture and the patient was taken to surgery for an open reduction of the fracture and casting. On the 11th post-op day she was examined and an area of redness from "cast irritation" along the back of her leg was noted. It was documented that this area was healing nicely.

Approximately two weeks later, she was examined and the area was still reddened. The physician recommended padding and an antibiotic cream. The patient later went on to develop an ulceration and eventually required aggressive treatment with split-thickness grafting.

A malpractice claim was filed claiming the physician improperly casted her leg and improperly monitored and treated the area of irritation. During the investigation of this claim it was discovered that there were two differing copies of the medical record. In one there was a short note regarding the area of irritation with the reeommendation of padding and antibiotic cream. The other was more comprehensive about the irritation and the treatment plan. When the original record was viewed closely, the longer version note could be seen pasted over the top of the shorter version. The physician admitted he "may" have gone back after he had been notified of the malpractice claim and clarified this note.

This claim was eventually settled due to problems in defending the care with two differing sets of medical records. Alteration of medical records can turn a medically defensible case into a loser because "innocent" additions or late dictation can be perceived as attempts to conceal mistakes.

Most alterations and additions are detectable simply because copies of records have already been released before the physician is made aware of the malpractice claim. Never alter or make additions to the record after notification of a bad outcome or malpractice claim. It's much easier to explain incomplete or unclear documentation at deposition than to explain additions that were made after the fact.

For more information contact Lori Atkinson, MMIC risk management supervisor, Midwest Medical Insurance Company, West Des Moines Office, PO Box 65790, West Des Moines, Iowa 50265; 800/798-9870 or 515/223-1482.

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Neurologist & Oncologist . . .

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- **Competitive compensation**
- **Exceptional services available at 162-bed local hospital, St. Joseph's Medical Center**

Brainerd, Minnesota

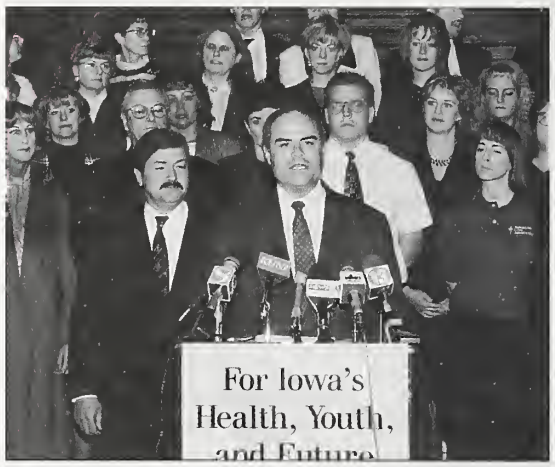
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Curt Nielsen
218/828-7105 or 218/829-4901
2024 South 6th Street
Brainerd, Minnesota 56401

Newsmakers

News at a glance

Blue Cross Blue Shield of Iowa (IASD) has entered into a nationwide search for a physician to fill the new position of chief medical officer. This position was created as part of a restructuring effort at IASD. Specifications for this job include extensive administrative and clinical experience in a national or regional managed care setting. If you or anyone you know is interested in becoming a candidate for this most senior level management position, contact Carol Emmott at SpencerStuart search firm, 415/495-4141.



Dr. William McMillan, IMS president, participated in a press conference announcing the filing of a lawsuit against the tobacco companies, at the Capitol in late November. Dr. Harold Miller also made remarks at a similar press conference held later the same day in Davenport. The suit seeks to recover Medicaid funds used to treat smoking-related illnesses.

Awards, appointments, etc.

Dr. Gene Herbek was recently awarded the 1996 CAP Foundation Lansky Award at the College of American Pathologists' Business Meeting. Dr. Herbek, a Sioux City pathologist, won the award for his "respected leadership consistent with the goals of the CAP Foundation" and significant contributions to the field of pathology. **Dr. Edmund Coyne**, Cardiovascular Medicine, PC, Davenport and **Dr. Kristen Wells**, Davenport Medical & Surgical Eye Group, PC were recently given the Davenport Family Practice Residency Preceptor Appreciation Award. **Dr. Joseph Lohmuller**, Davenport Surgical Group, PC, has been appointed to serve on the Committee on Trauma for the Iowa Chapter of the American College of Surgeons. Genesis Regional Heart Center vascular thoracic surgeon, **Dr. Thomas Mabee**, has successfully performed the Quad Cities' first right pulmonary valve transplant using human donor tissue. **Dr. Michael Jones**, Sioux City otolaryngologist, has been elected president of the American College of Surgeons, Iowa Chapter. The following physicians have recently joined Covenant Clinic in Waterloo: **Dr. Daren Tobert, Dr. Susan MacLellan-Tobert** and **Dr. David Woodbury. Dr. Tammy Jo Wells** and **Dr. Dolores Lowe** have begun practice in the new Family Care Northwest Clinic in Davenport. The clinic is affiliated with Genesis Health System. **Dr. Steven Wolfe** has been named executive medical director for the Mercy Family Care Network which is affiliated with North Iowa Mercy Health Network in Mason City. **Dr. Robert Hyungki Choi** has begun neurology practice in Waterloo. **Dr. Thomas Szymke** has joined **Drs. Farid Manshadi** and **W.H. Verduyn** of Physical Medicine & Rehabilitation Associates of Northeast Iowa in Waterloo. **Dr. Eromosele Otoadese** has joined Cardiac Surgery in Waterloo. **Dr. Eric Pepperl**, ophthalmology, has joined McFarland Clinic in Ames. **Dr. Christine Murphy** has begun dermatology practice in the Nevada branch of the McFarland Clinic. Dr. Murphy will also be seeing patients in Marshalltown and Webster City. **Dr. N.K. Pandeya** from Midwest Plastic Surgery Center in Des Moines, was recently awarded the Air Force Volunteerism Medal for his work in Haiti and with local medical students. Dr. Pandeya is the State Air Surgeon for Iowa. **Dr. Byron Beasley**, Mason City cardiologist, has been elected president of the board of directors of the American Heart Association, Iowa Affiliate. **Dr. Brett Richman** has joined Ob/Gyn Specialists, PC in Waterloo. IM

How to Collect for Control

An advanced training seminar designed to improve your success in preventing and collecting medical accounts receivable.

February 19
Mason City, Iowa
North Iowa Mercy
Medical Center
West Campus #6

February 20
Waterloo, Iowa
Allen College
McBride Auditorium

February 21
Davenport, Iowa
St. Ambrose
Professional Develop. Ctr.

? A patient arrives on Friday afternoon with an "emergency." This patient's account has already been sent to a collection agency because all efforts to collect have failed. How do you treat this person? What if it were a new account? A good customer?

? A divorced mother brings her child for services and asks you to bill the father for treatment. What if the accompanying parent is the custodial parent? Who is responsible for payment of the services? Should you request a copy of the divorce decree?

? The insurance company has sent the payment for services to the patient rather than your office. How do you get the check? What if the payment is for a lesser amount and it states that your fees are UCR? What if you have a contract with that insurance agency?

Do you know the answers to these questions? If not, you could be at risk for violation of the law—and fail to collect payment for the services you have provided. It is important to understand the legal limits of your position, how and when to finalize your accounts receivable and how to manage a healthy cash flow from your office.

IN ONE DAY WE WILL SHOW YOU HOW TO:

Control Systems

- Build a complete collection system
- Design an internal and external plan that works

Preventative Steps to Eliminate Collection Problems

- Create an effective financial policy for a sound foundation
- Utilize your best sources of information
- Identify potential problem payers
- Collect from insurance companies and attorneys quicker and with greater results
- Design collection letters with third-party influence

Effective Collection Call Planning

- Script your calls for greater effectiveness
- Set objectives before each call
- Choose specific words for the greatest effect
- Identify sources to obtain payment in full

Collection Calls for Control that Produce Results

- Handle stalls and objections more creatively
- Influence others to make and keep payment commitments
- Collect with third-party influence
- Stay in control of the telephone call
- Know how and when to finalize delinquent accounts

FACULTY

JEFF STAADS is a nationally known consultant and trainer, with extensive experience in health care operations and management. He is a master of collections, a motivational trainer and an instructor of collection strategies. As President of The Business Resource Center (BRC) for the past five years, Mr. Staads has developed the company's training and consulting programs. BRC provides both consultation and seminars for leadership/management, personal skills development and business/association development.

The professional associations for whom he has provided training and development programs include: American Academy of Dental Group Practice, American Association of Medical Assistants, Arizona Medical Association, Detroit District Dental Society, Indiana Dental Association, Kimberly Quality Care, Medical-Dental-Hospital Bureaus of America, Metro Omaha Medical Society, Oregon Society of Medical Assistants, Southern Medical Association, Specialized Pharmacy, State Medical Society of Wisconsin, Tennessee Medical Association, Texas Hospital Association, Washington State Dental Association, the Yankee Dental Congress and the Wisconsin Clinic Credit Managers Association.

Mr. Staads is adept and knowledgeable with the many facets of collecting including patients and third-party insurers. In addition, he has the ability to motivate managers and staff to be enthusiastic about collections and to improve their self-concept with practical tools that ensure success. Mr. Staads combines humor with expertise in this one-day workshop to improve the prevention and collection of your receivables.

Cost: $99 for IMS member or staff/$198 for nonmember (includes lunch)

★ THIS PROGRAM IS PART OF THE IMS MEDICAL BUSINESS SPECIALIST (MBS) CERTIFICATE PROGRAM.

REGISTRATION FORM

How to Collect for Control

Complete this form and mail it along with your check or money order to:
IMS Services, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, ATTN: Seminars

NAME(S) _____

OFFICE/CLINIC _____

ADDRESS _____

TELEPHONE _____ FAX _____

Are you or is your physician an IMS member? YES NO

Are you in the MBS Certificate Program? YES NO

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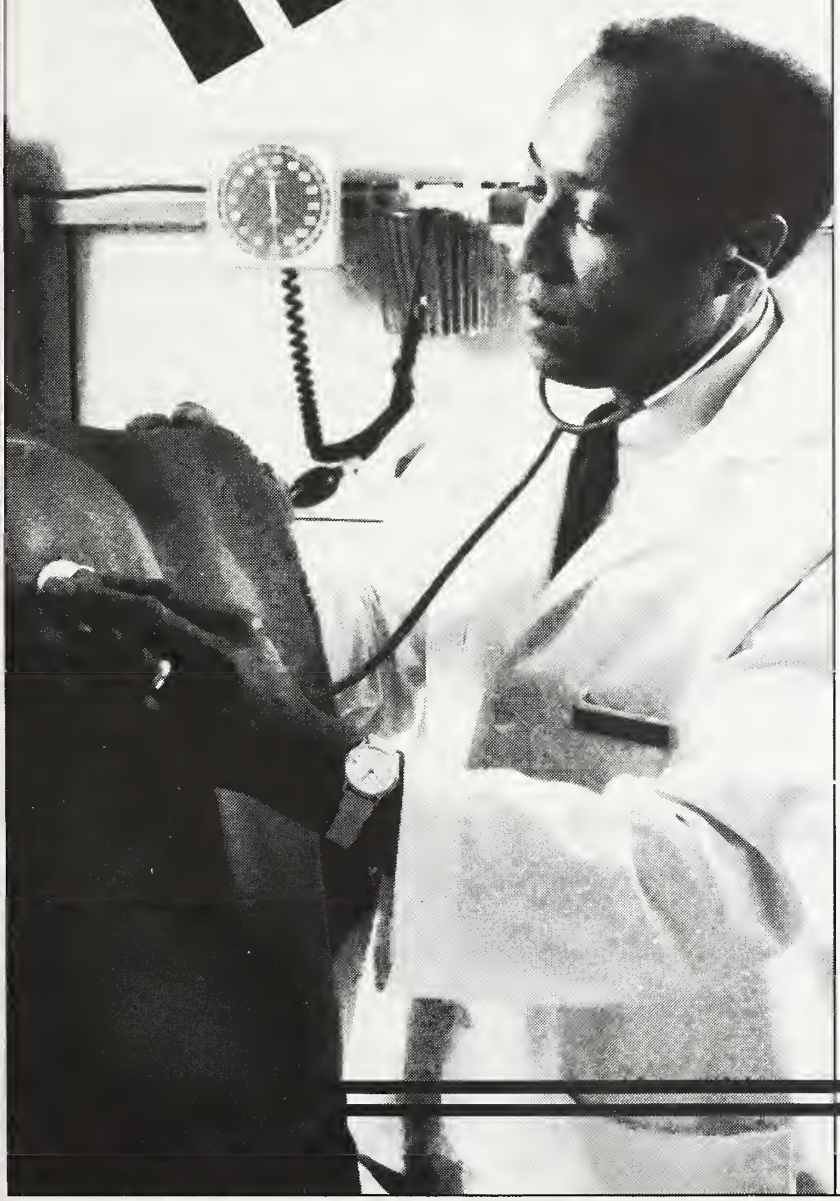
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AIR FORCE

EVP Abrams:

"I immediately felt comfortable with the medical society"

Michael Abrams, new executive vice president of the Iowa Medical Society, is making strategic planning and membership recruitment and retention his top priorities. Mr. Abrams also shares what he believes is the biggest challenge facing physicians and what the IMS can do to meet the needs of Iowa's physicians.

Q. Tell us about your background. What were your responsibilities at the Indiana State Medical Association?

A. I have a bachelors degree in political science from Indiana University and a masters degree in public administration, also from IU. My graduate degree has a concentration in public policy analysis.

I joined the Indiana State Medical Association in August 1987 as a lobbyist. In that capacity, I spent about 95% of my time lobbying the state legislature on health issues. After two sessions, my predecessor left to work for the state department of health and I was promoted to chief lobbyist and director of government relations. As a result of strategic planning, departments were consolidated and my new department (the Department of Government Relations and Marketing) was created. My department was responsible for federal and state government affairs, assistance to physicians who are addicted to alcohol and other drugs, practice management consulting, reimbursement ombudsman activities, membership recruitment and retention and data collection. I loved my work at ISMA because my department was responsible for such a wide array of issues, all of them critical to the medical society's success.

As physicians reinvent themselves professionally, their needs will change. IMS will be prepared to change with those needs.

Q. Why did you want to come to Iowa and to the Iowa Medical Society?

A. There are many reasons why Iowa is an attractive opportunity for my family and me. First, the state itself is a very welcoming place. We are very impressed with the education system and the people of Iowa. Second, the dynamics of the health community and Iowa physicians are quite similar to Indiana, so I immediately felt comfortable with the medical society. Finally, I believe that serving

MICHAEL ABRAMS
Mr. Abrams started with the IMS on November 11. He was director of the Department of Government Relations and Marketing at the Indiana State Medical Association prior to joining the IMS.

Iowa physicians as EVP of the Iowa Medical Society is going to be not only professionally challenging to me, but will also be very enjoyable! There are a lot of changes taking place in the medical community and the way in which physicians deliver care to their patients and it will be important for IMS to be involved with those changes and continue to be significant to our members.

Q. What will be your immediate priorities during your first year as Iowa Medical Society executive viee president?

A. A top priority will be strategic planning. I believe it is critical for organizations to constantly revisit their mission, their purpose, their core values; using this to guide their actions. What values do the IMS hold deeply? Why does IMS exist? What do we aspire to attain? Why should a physician belong to any medical society? What value to we add to their professional lives? How can we be more important, more indispensable to the practice of medicine? A good strategic planning process can help answer these types of questions and ensure that we are progressing with a vision of where were are going and what our role is.

Another priority will be membership recruitment and retention. As physicians reinvent themselves professionally, their needs will change. IMS will be prepared to change with those needs so that Iowa physicians continue to need IMS.

Finally, I want to spend a great deal of time learning the culture and the community. Until now, most of my exposure to Iowa came every four years during the presidential caucuses! It is important for me to learn how the medical community and the community at large work with IMS.



Q. We understand there will be a comprehensive strategic planning process for the IMS in early 1997. What will this entail? What do you hope to accomplish through this process?

A. The process will entail a lot of introspective study. What do our members want and need from an organization such as IMS? We need to learn that not from our leadership, but from the rank-and-file physician who is busy at practice in Anywhere, Iowa. The membership study will be conducted using a number of study tools, including a survey, focus groups and telephone interviews. Beyond that, there will be a series of lengthy meetings, off-site planning retreats and staff

continued

research intended to provide more information regarding our society's core values and purpose.

The intended result of the strategic planning process will be a fresh vision of IMS purpose: our mission statement, core values and the activities on which we intend to focus to accomplish our mission.

I believe it is critical for organizations to constantly revisit their mission, their purpose, their core values; using this to guide their actions.

Q. What is the biggest challenge facing physicians?

A. Physicians have always been empowered by the health system to advocate on behalf of their patients. I believe that one of the biggest challenges facing not only physicians, but patients, is the preservation of that patient-physician relationship—the ability for a patient and a physician to come together and decide a treatment plan and to pursue that plan without interference by government, payers or other entities not directly impacted by the decision.

Another major challenge for physicians is medical education and physician distribution. Managed care has raised some important issues about how physicians will be trained and how that educational process will be funded.

There are no easy answers to these challenges, but I am energized by the discussions and possible solutions.

Q. What can organized medicine do to support physicians in the new environment?

A. Hopefully our strategic planning process will allow us to focus like a laser on the most important things that physicians need, but I can imagine a few services that should be provided.

For example, there is a great demand for data. I believe that IMS should be the leader in collecting, analyzing and disseminating data on health care in Iowa, including outcomes, length of stay, charges, severity-adjusted complication and mortality data and similar information. We are uniquely equipped to do this because of the expertise available throughout our membership.

Second, I sense a demand for assistance with practice management issues. Perhaps we can be helpful to physicians as they go through the painful process of reinventing themselves and answering such pressing questions as "should I participate in a PHO or a PH" or "should I become a hospital employee?"

Q. What do you enjoy in your leisure time?

A. I love to read. And when I read, I do not necessarily seek out books that only relate to my profession. I find that a good book helps me relax and enjoy life, so I am almost always working on a book. I love any book by Sinclair Lewis and I enjoy reading books about history. I can also enjoy a good Grisham novel!

My wife and I also enjoy short day trips. If we have some time, we enjoy getting in the car and traveling a few hours away to stay in a town and explore a new area. Moving to Iowa has opened up lots of new possibilities for day trips!

Golf is also a hobby of mine, although I just recently took it up and am not at all good. I am that dangerous combination: a bad golfer who truly loves the game.

Q. If you could invite anyone to a dinner party who would you invite?

A. I would invite Jesus Christ, Wolfgang Amadeus Mozart and Thomas Jefferson. That should provide some stimulating conversation! IM



Can you afford to ignore the Internet?

Probably not. Nearly 40 million people already have Internet access, and that number is expected to grow to 300 million people in the next three years. It truly is a new form of communication that's here to stay.

Besides, you're missing a wealth of information by not using the Internet. The Internet is a 24-hour virtual library of medical resources. The Internet also allows the exchange of e-mail and real-time discussion groups for doctors and patients.

With the Internet you can research the uses of a new prescription drug or communicate with colleagues around the world about new treatments.

Now is the time to jump on the Web

If you've been thinking about getting Internet access, now is the time. The Iowa Medical Society (IMS) has launched its web site, and it's something you don't want to miss.

The IMS web site makes it easy for Internet novices to find the information they need as they explore this new medium. Experienced users discover that the IMS web site will cut down their surfing time by making resources available at a click of the mouse. We're linking IMS physicians to the information they need!

Already on the Internet?

Jump to page 4 to find out how to get your password for the IMS web site.

What is the Internet?

The Internet is a giant network of interconnected computers. Through this global network, users can send e-mail, talk to other people in discussion groups and view web sites on the World Wide Web.

The World Wide Web is the part of the Internet that allows graphics, what you generally think of as the flashy part of the Internet. The other features of the Internet, such as e-mail, are text-based.

What do you need to get connected?

To get connected to the Internet you will need a computer, a modem, a telephone line and the software to link your computer to an Internet service provider. You will also need an account with a commercial online service or an Internet service provider.

Computer: Remember that your Internet software and your current software will run at the same speed. If your computer is sluggish now, it will be sluggish in cyberspace as well.

Most Internet service providers recommend that you have 16 MB of memory and at least a 486 processor for PCs. A system with a Pentium processor works best for the Internet. Macintosh computers work best running on System 7 or higher with 8 MB of memory and 3-5 MB of disk space for applications.

Modem: The faster your modem, the better it will be for using the Internet. Modems slower than 14.4 Kpbs will be frustrating to use. If you are buying a new modem, get a 28.8 Kpbs modem.

Telephone line: You might consider getting a separate telephone line for your modem, unless you don't mind having the line tied up while you are using the Internet.

Software: You will receive easy-to-install software from the commercial online service or Internet service provider when you set up an account. Make sure you also purchase a browser program, such as Netscape Navigator or Microsoft Internet Explorer. These programs allow you to view web sites on the World Wide Web. Many Internet service providers include these programs with their software.

How do you choose a service provider?

There are two primary ways to get connected to the Internet: through a national commercial online service such as CompuServe or AmericaOnline, or through a dedicated Internet service provider.

When deciding which route to take, consider that providers don't all charge in the same way. Find out the initial set-up fees and monthly charges.

Also ask about whether you can access the service by calling a local number. If you can't call a local number, you will pay long distance phone fees for the time you are connected to the Internet.

What is best for you depends on your use of the Internet. Commercial online services are easy for new users, but they limit the number of hours you can use the service each month. After reaching that limit, you pay for additional time. Internet service providers generally have more flexible plans based on the amount of time you expect to be using the Internet.

Internet service providers

Commercial online services

These national providers offer local access numbers for most Iowa communities.

CompuServe	800/336-6823
AmericaOnline	800/827-6364
Prodigy	800/776-3449

Iowa Internet service from local telephone companies

Iowa Network Services is a consortium of local telephone companies providing local Internet access in over 300 Iowa communities. Call your local telephone company for pricing and availability of Internet access. You can also call Iowa Network Services at 800/546-6587 for the participating company nearest you.

Other Iowa Internet service providers

Over 45 other Internet service providers operate in Iowa. You can find providers in your area by looking under "Internet services" in your phone directory or by calling Melanie Finke at the Iowa Medical Society at 800/747-3070. Physicians in the Des Moines area can purchase Internet service from Healthcare Solutions Group, the company that developed the IMS web site, by calling 800/391-3713.

IMS site links you to information you need

Why is now the perfect time to jump into the Internet world? Because the IMS web site will make it easy for you. The IMS web site gives physicians daily medical news, legislative updates and medical practice advice. The IMS web site also includes links to the best medical resources on the Internet.

- Find IMS position papers, updates on activity during the legislative session and links to legislators on the "Legislation and Public Policy" page.
- The 1995 E&M utilization data for Medicare is available on the "Medical Practice and Economics" page. You can also access the Practice Management Question of the Week and coding change updates.
- Register for upcoming practice management seminars and IMS conferences on the "Events and Seminars" page.
- Read up on the latest medical and legal news from the short media clips on the "Medical News" page.
- Communicate with IMS staff by e-mail on the "About IMS" page.

This is just the beginning. We will change and add to the IMS web site to meet physicians' needs. That means we want to hear what you think about the IMS web site. To give us your opinions, just click the "Feedback" button on our site.

How do you access the IMS site?

Simply type in http://www.IowaMedicalSociety.org. Some sections of the web site are for IMS members only, so you will need to call Laura Nelson or Melanie Finke at 800/747-3070 to receive your personal password. Typing in your name and password when you are prompted will allow you to view information on the "Legislation and Public Policy" and the "Medical Practice and Economics" pages. Your practice managers or administrators can access these sections also by using your name and password.

Call IMS at 800/747-3070 for your password today!

Combatting fraud and abuse

Anti-Kickback Statute

As the Medicare and Medicaid programs have become a larger part of the federal budget, the government has increased its resources for discovering and prosecuting fraud and abuse. Enactment of the 1996 Health Insurance Portability and Accountability Act (Kassebaum-Kennedy) enhanced the federal government's ability to combat fraud and abuse.

One of the main tools likely to be used for prosecution is the Federal Health Care Program Anti-Kickback Act. In an environment where the roles and relationships of physicians are changing, this law causes concern. Because of the law's broad language, it is uncertain whether a wide array of business practices such as discounts, investments in health care entities and compensation arrangements are prohibited.

What's prohibited?

The Anti-Kickback Statute prohibits knowing and willful solicitation or receipt of remuneration, including any kickback, bribe or rebate, in return for making a referral or purchasing, leasing or ordering equipment that may be paid for by state or federal money. The law also prohibits the knowing and willful offer or payment of remuneration to induce such activity. A violation of these provisions is a felony punishable by up to five years imprisonment and/or up to $25,000 in fines. The Office of Inspector General of the Department of Health and Human Services (DHHS) also may exclude an individual from federal health care programs.

The potential range of prosecutions should not be underestimated. It covers many activities including employee/employer relationships, rental of space or equipment, ownership interests in health care entities and participation as a provider in managed care plans.

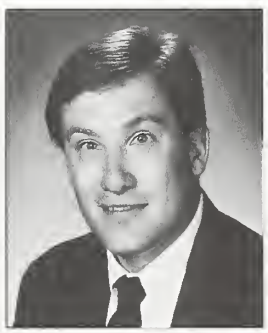
The jurisdiction of the government over such claims should not be underestimated. One referral of a Medicare or Medicaid (or other federal health care program) patient can subject a physician to the law; there is no requirement to show harm to the patient or the government. Courts have held if just one purpose of the payment is to induce future referrals, the statute has been violated.

Safe harbors

Fortunately, the law provides for certain exceptions as well as "safe harbors". The statutory exceptions include bona-fide employment relationships, certain discounts and payment of administrative fees by vendors to certain group purchasing organizations of providers. Kassebaum-Kennedy created an important exception for risk-sharing arrangements such as remuneration to a physician pursuant to arrangements that place the physician at substantial financial risk for the cost or utilization of items or services the physician is required to provide.

Regulations implementing the Anti-Kickback Act provide safe harbors that cover various business relationships. The safe harbors address investment interests, space and equipment rentals, personal services and management contracts' sale of practices,

continued



WILLARD BOYD III
Mr. Boyd is an attorney with the Nyemaster, Goode, McLaughlin, Voigts, West, Hansell & O'Brien, PC law firm in Des Moines.

referral services, warranties, discounts, employment arrangements, group purchasing organizations and waiver of beneficiary coinsurance deductible amounts.

Proposed safe harbors exist for other types of activities including physician recruitment and cross referral arrangements for specialists. While these safe harbors would appear to cover many activities, each contains several requirements that often make it uncertain whether legitimate conduct actually falls within a safe harbor.

One referral of a Medicare or Medicaid patient can subject a physician to the law; there is no requirement to show harm to the patient or the government.

While failure to meet the requirements does not necessarily mean a physician has violated the law, falling under a safe harbor does give the physician comfort in knowing that the conduct will not be challenged. Under Kassebaum-Kennedy, a procedure for public participation in the safe harbor development process has been established.

Kassebaum-Kennedy also allows requests for advisory opinions by the DHHS Office of Inspector General to clarify the law's application. While such opinions are binding only on the requesting party and DHHS, they should provide guidance. DHHS has issued special fraud alerts that provide guidance on various types of arrangements, including hospital-based physicians, physician practice acquisitions, hospital incentives to physicians and joint venture arrangements.

"Knowingly and willfully"

An essential requirement in showing a violation of the law is that the action of the provider must be knowing and willful. In a 1995 case decided by a California federal appellate court, *Hanslester Network v. Shalala,* physician self-referral joint ventures were challenged as "shams" used as conduits for payment to physicians for referrals. The court found "ample evidence" that defendants intended to encourage physician-owners to refer business to the joint venture laboratories and offered physicians the opportunity to profit indirectly from referral when they could not profit directly. The court found the defendant providers believed their conduct to be lawful and held that the "knowingly and willfully" requirement of the law required proof that the provider knew what the statute forbade and intended to disobey the law.

The U.S. Court of Appeals for the Eighth Circuit rendered a decision in 1996 also interpreting the "knowingly and willfully" requirement. In *United States v. Jain,* the appellate court reviewed a trial court's conviction of a physician in which there was evidence that remuneration under a marketing agreement between a hospital and the referring physician was not for marketing services but for patient referrals. The government argued that "willfully" under the statute referred to consciousness of the act but not consciousness that the act is unlawful. The defendants argued that the standard used in *Hanslester* should be adopted. The trial court "adopted a middle ground" and interpreted "willfully" to mean unjustifiably and wrongfully, known to be such by the defendant. The trial court instructed the jury that "good faith" was a defense to this charge, explaining the physician acted in good faith if he believed he was being paid for promoting the hospital, not for referring patients. The court concluded that the government needed to prove the physician knew his conduct was wrongful, rather than prove he knew it violated a known legal duty.

While the "heightened" willfulness requirements set out in *Hanlester* and *Jain* decisions appear helpful to providers, they could be overruled by the U.S. Supreme Court. It is important for physicians to follow developments in this area. IM

Your blueprint to financial independence

In today's complex financial environment, understanding what you want to accomplish and developing a strategy for meeting your objectives is critical.

If you have ever been in the market for a financial planner, you have probably seen two approaches to the process. First, you probably talked with a planner who displayed a sample financial plan that's several inches thick. Your plan would look the same as the sample except names and numbers would change. It's generally a boilerplate plan that doesn't allow for flexibility to address your needs.

You may have then walked down the street and talked to the next planner whose plan represents a "needs analysis" that will show a definite need for additional life insurance—which he or she can provide to you.

Neither one of these is necessarily wrong. However, a financial plan is not just the finished product. A true financial plan is never done. Financial planning is a process; a relationship built upon the need to define and redefine goals and create and implement solutions to problems. The finished product is the blueprint, the map to your financial independence. At this point the relationship with your planner becomes critical as you work together to follow the blueprint.

I suggest you categorize your planning into three major strategies:

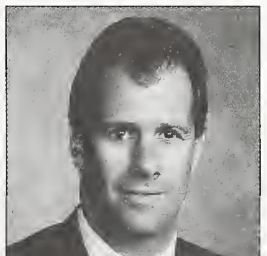
Accumulation phase: This is the process of defining goals you have for education costs, vacation home, retirement, etc. and establishing a plan to meet them.

Management phase: How do you manage the assets and effectively utilize your income sources? This requires a disciplined investment strategy that includes a written investment policy and systematic approach to tax planning strategies.

Distribution phase: This process is necessary to ensure your retirement objectives are met by establishing an income distribution strategy that will integrate social security, retirement plan assets, real estate income, part-time work, inheritance, etc. Planning early will help maximize income by minimizing the potentially devastating effect of various tax laws. You should also develop a strategy for your estate in the event of your death. Proper planning can minimize the tax your estate will pay.

Financial planning is a process; a relationship built upon the need to define and redefine goals and create and implement solutions to problems.

There are many strategies you can implement in financial planning. What makes sense today may not later because of changing circumstances. That's why financial planning is not a book on your shelf that is never reviewed. Financial planning is a relationship with a professional who will work as an advisor and advocate for your personal and financial objectives. IM



JERRY FOSTER

Jerry Foster is the founder and president of Foster Capital Management, a fee-based financial advisory firm endorsed by the Iowa Medical Society. Mr. Foster can be reached at 1-800/798-1012.



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The Journal
of the Iowa Medical Society

Current therapy of Parkinson's disease

● *Todd Ajax, MD; Robert Rodnitzky, MD; Judith Dobson, RN*

Editor's note: ***This is the first part of a two-part article. Part 2 will be published in the February issue.***

Parkinson's disease (PD) is one of the most common neurologic disorders cared for by neurologists and primary care physicians. It is characterized by the cardinal clinical features of tremor, rigidity, bradykinesia and postural instability. Three of these four features are needed for a firm clinical diagnosis, but the manifestations of Parkinson's disease in individual patients are quite variable, ranging from all four cardinal features to a more benign presentation predominantly with tremor.

Other disorders may mimic idiopathic PD and are collectively referred to as the parkinsonisms. In these conditions. one or more of the cardinal clinical signs of PD are present, most often akinesia and rigidity. Additional atypical features such as onset at an earlier age, more rapid progression, autonomic instability, supranuelear gaze palsy, cerebellar signs or pyramidal tract involvement assist in distinguishing parkinsonism from idiopathic PD. Another important diagnostic point is that idiopathic PD responds to levodopa in the majority of cases, whereas in parkinsonism the therapeutic response is less prominent or absent, and if present, short lived.

The parkinsonisms include disorders such as progressive supranuclear palsy, multiple systems atrophy and corticobasal ganglionic degeneration. Acquired parkinsonism may result from such varied causes as multiple subcortical strokes involving the basal ganglia and cerebral white matter, dopamine blocking or depleting medications and certain toxins.

The medical and surgical treatment of PD has developed greatly over the last 25 years since the introduction of levodopa. With the increased number of treatment options now available, it has become critically important to understand when and how to institute treatment to allow the patient to return to a normal lifestyle.

Treatment in early Parkinson's disease

An assessment of the patient's lifestyle impairment and discomfort is required in deciding when to institute treatment. Frequently, at the time of diagnosis, clinical signs and symptoms may be present, but there is no disability. The presence of occupational, cosmetic and social disability all need to be explored. If the manifestations of PD are affecting any of these realms and impairing lifestyle, symptomatic therapy should be instituted. If impairment in lifestyle cannot be identified, there may be benefit from delaying treatment.

Complications after long-term therapy with levodopa may include motor fluctuations, dyskinesias and early morning dystonia. However, there is controversy as to whether these adverse outcomes develop from chronic exposure to the medication, as a result of progression in the primary disease process or from both. Some experimental data suggests that early institution of levodopa may increase the oxidative stress on surviving dopaminergic neurons in the substantia nigra accelerating neuronal loss.

Accordingly, in early mild PD, where there is little or no disability, strong consideration should be given to instituting therapy with an alternative medication. These include selegiline (Eldepryl), amantadine (Symmetrel) or anticholinergic medications such as trihexiphenidyl (Artane) or benztropine (Cogentin).

The IMS Education Fund has designated this article as the Henry Albert Presentation Award for January 1997.

Todd Ajax, MD
Robert Rodnitzky, MD
Judith Dobson, RN
The authors are associated with the Department of Neurology at the University of Iowa College of Medicine, Iowa City, Iowa.

Current therapy of Parkinson's disease

continued

Selegiline

Selegiline, in low doses, is a selective inhibitor of the the enzyme monoamine oxidase-B (MAO-B). At recommended dosages there is no risk for the hypertensive crises seen in patients ingesting tyramine containing foods while receiving the non-selective antidepressant monoamine oxidase inhibitors. Selegiline has been shown to delay the need for more potent dopaminergic therapy when used in early mild PD.

Despite its mechanism of action, the ability of this medication to delay therapy with more potent dopaminergic medications makes it an excellent choice for treatment in early mild PD. Because of its potential for neuroprotection, treatment should be considered in patients with no disability. The recommended daily dose is 5 mg twice daily, morning and noon, since doses later in the day may result in insomnia. Due to its irreversible inhibition of MAO-B, treatment with 5 mg per day may be as effective and reduce cost and side effects. Potential serious drug interactions have been reported in a small number of patients taking selegiline and tricyclic antidepressants or serotonin reuptake inhibitors. Although recent studies have suggested this interaction is extremely rare, some have been fatal secondary to autonomic nervous system involvement.

Amantadine

Amantadine may result in mild improvement in the symptoms of PD, partly through enhancing the release of dopamine from surviving nigrostriatal nerve terminals. However, benefit may begin to wane after two or three months of therapy and often is absent after a year. The initial dosage is 100 mg twice daily. This medication may cause confusion and hallucinations in some elderly patients with PD. Other side effects include livedo reticularis and ankle edema.

Anticholinergics

Anticholinergic medications are most effective for treatment of PD tremor. Other features such as bradykinesia, postural instability and rigidity are less often improved. Therefore, anticholinergic medications are a reasonable choice in patients whose major disability arises from tremor. The two most commonly used medications in this category are trihexyphenidyl (Artane) and benztropine (Cogentin). These drugs have the potential anticholinergic side effects of visual blurring, urinary retention, sedation and constipation as well as increasing intraocular pressure in patients with closed angle glaucoma. In elderly patients the risk of causing confusion, hallucinations and impaired memory exists. Anticholinergic medications should therefore be used cautiously and in low dosages in the elderly and avoided in patients with any evidence of dementia. With a gradual increase in the dose of anticholinergic medication, a great deal of the peripheral side effects can be avoided. Trihexyphenidyl should be begun at 1 mg twice daily and increased by one tablet per week to a dose of 2 mg three times daily, if tolerated. Benztropine may be begun at 0.5 mg per day and increased to 1 mg twice daily. If these medications must be discontinued they should be tapered off slowly due to the risk of rebound worsening of PD symptoms with abrupt cessation.

Moderately advanced disease

Patients in this group have disability beyond that which can be managed effectively with selegiline, amantadine or anticholinergics alone. This level of disability requires therapy with levodopa. The long-term implications of levodopa therapy include a 30–50% incidence of motor fluctuations and/or abnormal involuntary movements after five years of therapy. Therefore, avoidance of premature therapy with levodopa and administering the lowest possible dose for symptomatic control is advised.

Levodopa

Levodopa is administered along with carbidopa in a combined tablet (Sinemet). Carbidopa is a peripheral inhibitor of dopa decarboxylase, the enzyme responsible for the peripheral metabolism of levodopa to dopamine. Peripheral inhibition of this enzyme reduces untoward side effects of

levodopa, most notably nausea. Most patients require around 60 to 150 mg of carbidopa. Therefore, the 10/100 mg dosage form of carbidopa/levodopa may not provide adequate carbidopa to reduce these peripheral side effects. Supplemental carbidopa tablets (Lodosyn) at a dose of 50 to 75 mg per day may be required for nausea that may accompany treatment with carbidopa/levodopa tablets.

Carbidopa/levodopa is available in standard release (Sinemet) and sustained release preparations (Sinemet CR). Standard Sinemet is less expensive and is available in generic form. Sinemet CR has the advantage of fewer daily doses. Sustained release Sinemet also reduces the pulsatile stimulation of striatal dopamine receptors related to the periodic ingestion of levodopa by providing for a more continuous plasma level of levodopa. This may reduce the development of motor fluctuations and dyskinesias.

Some physicians may choose to initiate therapy with sustained release carbidopa/levodopa 25/100 twice daily for the first week and increase to 50/200 twice daily. The medication's effectiveness should be evaluated after the first month. Due to the slow release of levodopa and its longer latency for onset of action, especially in the morning, additional administration of one-half to one tablet of a standard 25/100 carbidopa/levodopa tablet upon awakening may be recommended to speed the onset of effect with this first dosage.

If the sustained-release preparation is not chosen as initial therapy, the standard preparation may be tried at a dose of one-half of a 25/100 mg tablet three times daily and increased after seven to 10 days to one tablet three times daily. If the clinical response is suboptimal after one month, a further increase in the dose should be considered. If levodopa doses over 800 mg are required, the addition of a dopamine agonist such as bromocriptine or pergolide should be considered before adding more levodopa. Selegiline may be continued for its potential neuroprotective and levodopa-sparing effects. Similarly, anticho-linergic medications may provide added benefit in relatively young patients with prominent tremor. IM

Happy New Year from the IMSA members

The Iowa Medical Society Alliance Board of Directors and past IMSA presidents extend best wishes to you and your family for a prosperous 1997!

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Drug-seeking patients

Every doctor is troubled by a handful of patients with chronic pain and/or anxiety. The doctor is torn between a desire to relieve suffering and the concern over being dooped by an addict.

Whether legitimate patients or bonified addicts, these individuals are a source of frustration and anxiety for doctors and staff. Drug-seeking behavior can become tiresome, especially when demands of more seriously ill patients are present in a busy practice.

Through my experience as a family practitioner and director of several chemical dependency programs, I have found a solution. It stems from a technique used in all treatment programs known as a "contract". Once it has been determined a patient has exhausted all other reasonable treatment alternatives (i.e., pain center, nerve block, etc.) but still has chronic pain and/or anxiety for which ongoing analgesics and/or psychotropics are indicated, a contract is drawn up in the form of a letter. The letter specifies the medication to be used, the dosage and the number to be taken per specified time frame (usually two to four weeks). It also specifies how often the medication may be refilled and at which pharmacy. The letter contains a provision that the contract is valid so long as its terms are followed. A copy is sent to the patient, pharmacist and State Board of Pharmacy. If the physician learns any other physician or pharmacy is prescribing or dispensing medications, the contract and the doctor-patient relationship will be terminated.

The office is no longer under siege by calls from the patient and pharmacy for refills. The patient is far less anxious about obtaining relief from pain and has a clear understanding of how the system works. This system is also useful when the prescribing physician is not available. Most partners are reluctant to prescribe narcotics or psychotropics for patients with whom they are unfamiliar. I generally leave written prescriptions with my nurse for any "contract" patients before leaving for vacation.

The fear of being conned by addicts is also eliminated since addicts (or those seeking prescription drugs for re-sale on the street) will inevitably need a larger supply than one physician can provide. It's only a matter of time until they are found out and you can sever your relationship and alert the Board of Pharmacy. Often this leads to treatment intervention for the patient.

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Most important, however, is our legitimate concern and compassion for those who are truly suffering. This simple contract allows us to provide for appropriate, compassionate care without the apprehension usually associated with chronic pain and/or anxiety patients. IM



STEPHEN ECKSTAT, DO

Dr. Eckstat is a family practitioner with Mercy West Medical Clinic, Des Moines.

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In 1840 Dr. John B. Elbert came from Ohio to Keosauqua. His boundless energies lead to his election to the Territorial Legislature in 1842. He enjoyed a fine reputation as a surgeon, having received honorary degrees from the University of Missouri and the University of Pennsylvania. He was a charter member of ISMS and was elected its third president in 1852.

In 1838 Dr. Henry Murry located in Iowa City. Born in Ireland, a graduate of the University of Louisville, Kentucky, he was the first physician to settle in the present limits of Johnson County. In the same year a Dr. Ezra Bliss came from Vermont to Iowa City, but in a few years he moved to New York City.

The Iowa State Medical Society was formed in June 1850 when 25 physicians met in Burlington under the impetus set by Dr. John F. Sanford of Farmington. Inspired while attending the third annual meeting of the AMA he went by stage to Keosauqua, Fairfield, Mt. Pleasant, Washington and Davenport and by steamer to Muscatine, Burlington, Ft. Madison and Keokuk espousing the need for a state medical society.

The Iowa State Medical Society was formed in June 1850 when 25 physicians met in Burlington under the impetus set by Dr. John F. Sanford.

Early physicians in the newly-opened territory of Iowa often received their medical training under the supervision of a preceptor. The first preceptor in Iowa, according to available records, was Dr. Isaac Galland who founded the settlement known as Nashville, located a few miles north of Keokuk. Berryman Jennings was one such individual who learned medicine from Dr. Galland. Numerous other physicians assumed the position of preceptors; some for good cause, others to have someone to do chores for them.

As time passed medical schools were established in the midwestern territories. Early medical schools were established in Rock Island, Davenport and Keokuk. Others, all relatively short-lived, were later established in Council Bluffs, Sioux City and Des Moines. Actually, several schools were established in Keokuk. The University of Iowa College of Medicine was established in 1868, opening in the fall with a faculty of eight for 37 students, 10 of whom were women.

One year prior to statehood Dr. Thomas K. Brooks was the first civilian physician to practice in Polk County. By 1851 he had become so engrossed in various enterprises that the medical practice became secondary. Several other physicians came to Des Moines for short periods of time, their interests drifting eventually elsewhere.

During the 150 years which we recently celebrated, numerous physicians made their mark in the annals of Iowa. It is fitting that during this sesquicentennial year the University of Iowa College of Medicine and Hospitals and Clinics has been cited as outstanding among medical facilities in the U.S. IM



MARION ALBERTS, MD

EDITOR'S NOTE: THIS IS PART TWO OF A TWO-PART SERIES WHICH IS CONTINUED FROM THE NOVEMBER–DECEMBER 1996 ISSUE.

SERVICE

def.: to act or treat beneficially; to answer the needs of others.

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The ethics of selling snake oil

This title served me recently at one of our "Ethical Dilemmas" noon forums, prompted because I felt bombarded by mail advertising and the medical and public media. I first established that my audience knew "snake oil" to mean "a valueless mixture or concoction formerly sold as medicine by hucksters in traveling shows," but I emphasized how contemporary are such products and ideas, and how ubiquitous the sellers.

I'd been invited to sell to patients from my office, for example, products under my own label, not only to beautify the skin but to keep it forever youthful; a device to produce a non-surgical face lift; a 5% vitamin K cream to make spider veins disappear; flexible magnets to relieve pain by sending forth negative fields to counter the "positive fields associated with pain"; nutritional supplements of all sorts, including megavitamins, melatonin and DHEA, with careful wording to avoid the treatment of disease and thus escape FDA scrutiny.

Trying to understand the phenomenon, I distinguished conscious falsity (i.e., fraud) from unwitting or unconscious untruth or stretching the truth; ignorance; naiveté; a belief system deeply rooted in values different from mine (e.g., dependence on religious ideas, trust in testimonials, childish belief in the veracity and motives of the media); or exploitation of the placebo effect for all it's worth, including money-back guarantees to the dissatisfied. An "ethical company" used to mean one that advertised its products exclusively to physicians. Now pharmaceutical advertising is also directed to the public, but because the items require a prescription, patients are urged to "ask your doctor whether this product might help you" (sometimes with a free coupon). Even such a formerly taboo topic as impotence appears in ads that invite those affected to seek instruction about drug injections directly into the penis to produce an erection.

Advertising by physicians themselves has become popular since an FTC ruling scared away any who might protest, via threat of federal anti-trust action. So now some medical specialty societies as well as individual entrepreneurs are willing to sell assistance to advertise yourself and your services on the Internet.

An "ethical company" used to mean one that advertised its products exclusively to physicians.

Many ads offer me help in enlarging my practice (read, income). The academic world is likewise enmired in potential and actual conflicts of interest, but that topic needs far more space. What separates honesty from fraud, gullibility from arrogant skepticism? Where lies the patient's best interest? It's buzzing, booming confusion indeed. If attitudes and guidelines aren't soon clarified, the new sorts of carnival hueksters will clutter cyberspace, too. IM



RICHARD CAPLAN, MD

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Fort Dodge, Iowa—A busy otolaryngology practice is seeking locum coverage for weekends and some vacation time. Housing, transportation and malpractice provided. Send CV to Cindy Fellers, 800/360-4442; 804 Kenyon Road, Suite N, Physicians Office Building, Fort Dodge, Iowa 50501.

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Advertising Rates and Data

Regular classified advertising sells for $2.00 per line with a $30 minimum per insertion. For members of the Iowa Medical Society the rate is $20 per insertion. Display classified advertising sells for $25 per column inch, per month. Sizes range from 1 column by 2 inches to 1 column by 6 inches. A variety of type sizes, borders, reverses or screens can be included in the ad. Blind box numbers are available upon request at no additional charge. Copy deadline is the 1st of the month preceding publication. Send or fax copy to *Iowa Medicine*, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

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Cedar Rapids 52403
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Michael L. Long, MD
Bradley L. Isaak, MD
Randall S. Brenton, MD
James L. Dummett, MD
Mick E. Vanden Bosch, MD
3121 4th Street, S.W.
P.O. Box 1877
Mason City 50401
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(Continued next page)

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Des Moines 50314
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Thomas A. Simpson, MD
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Iowa Head and Neck Associates, PC
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Des Moines 50312
515/274-9135

Wolfe Clinic, PC
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Daniel J. Blum, MD
309 East Church
Marshalltown 50158
515/752-1566

Lakeview Medical Park
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West Des Moines 50266
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Sartori Professional Building
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Cedar Falls 50613
319/277-3105
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Ginni DeWees, RN, Program Director
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Cedar Rapids 52401
319/399-2013
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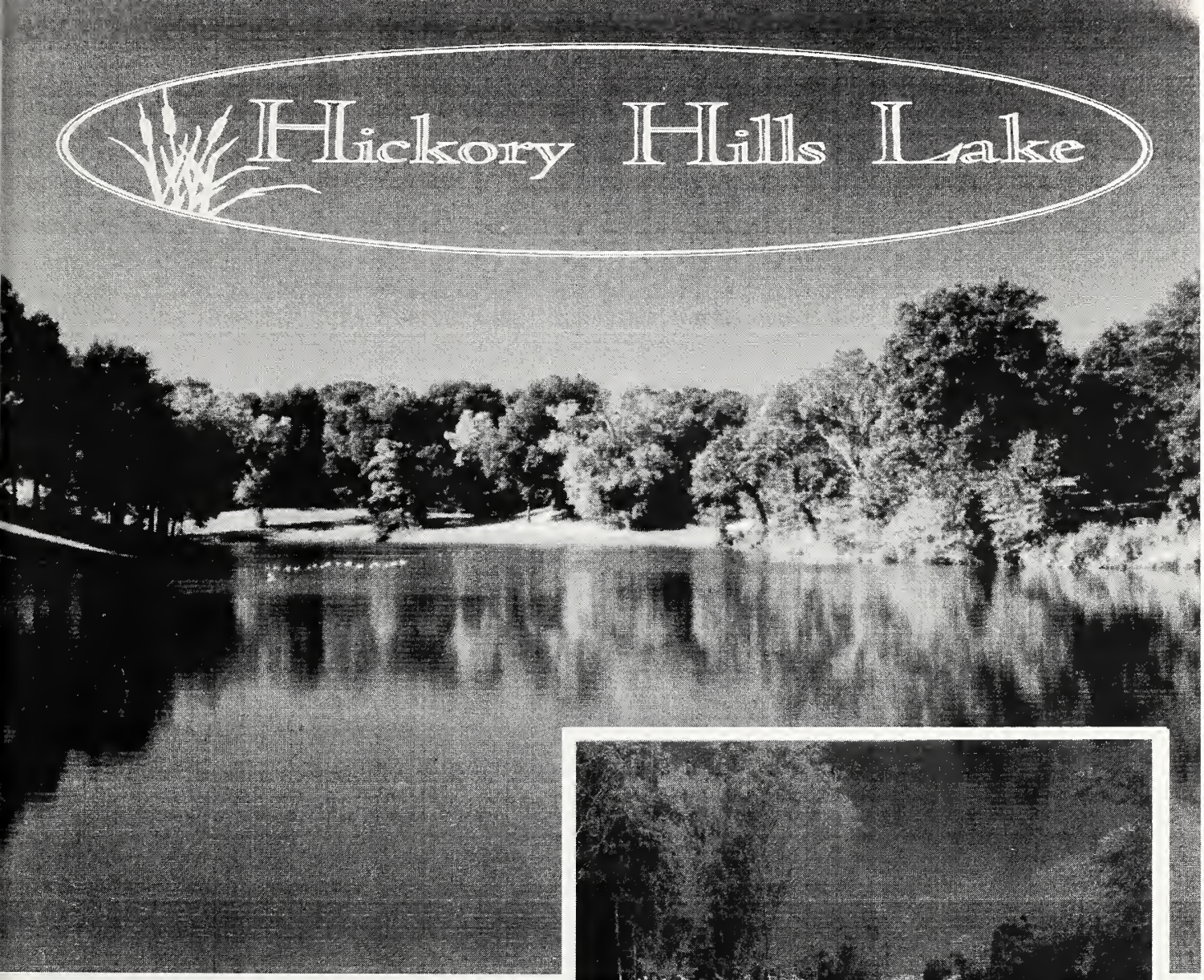
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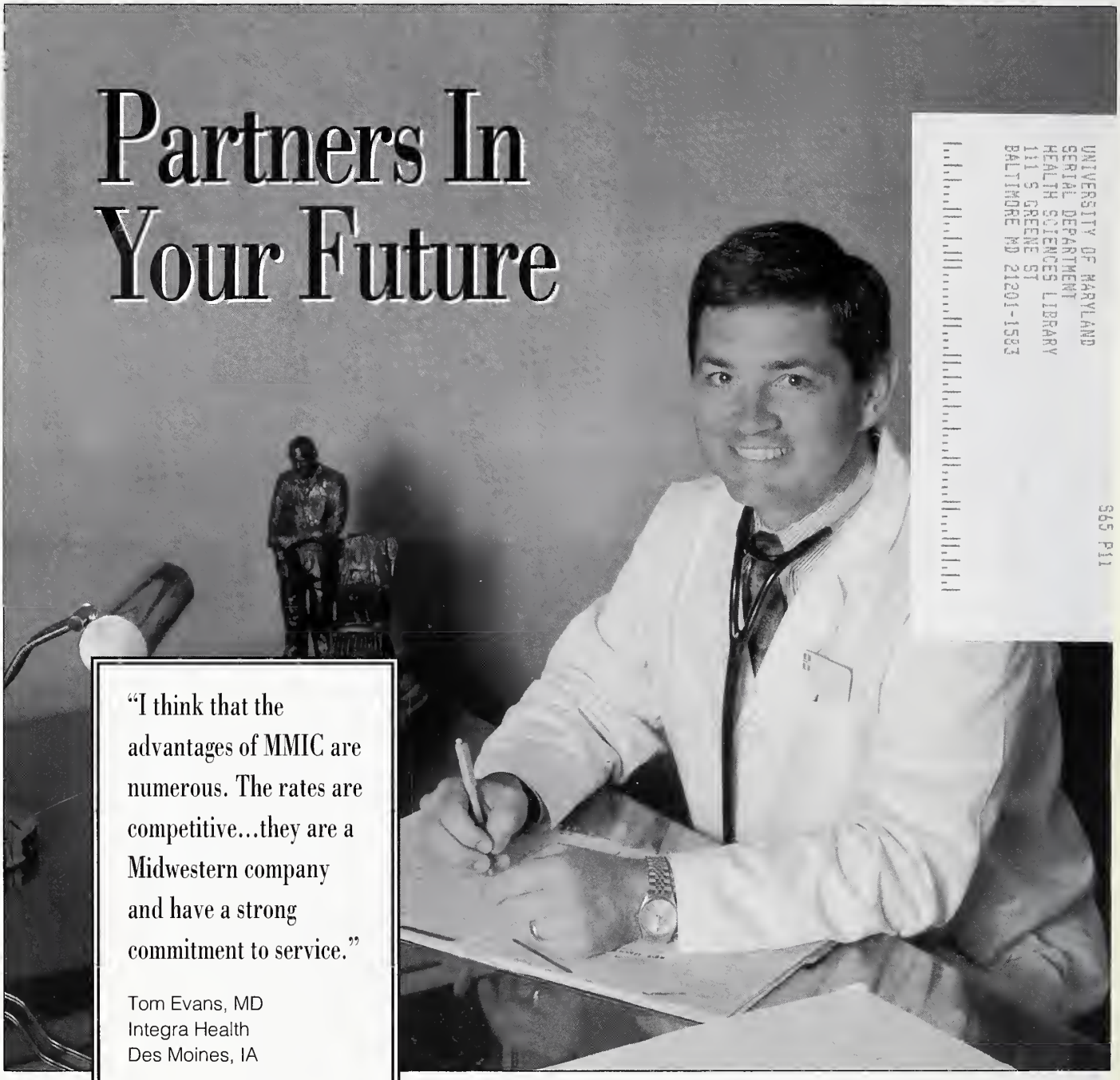
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Keynote speaker at the IMS Scientific Session Friday, April 18 will be Jacque Sokolov, MD, nationally recognized expert in physician organizations. For a preview of his presentation, look on page 66

Patient satisfaction is constantly assessed at Cedar Valley Medical Clinic
See page 53

ON THE LIGHTER SIDE

Friendship Providers . . . *Managed care principles applied to personal relationships, page 65*

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IMS *DEADLINE* news

February, 1997

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●**IF YOU HAVE BEEN THROUGH THE EXPERIENCE OF A LAWSUIT** or a malpractice claim and would like to help colleagues being sued, you might be interested in becoming a volunteer physician in the Physician Litigation Support Program. The program is being established through a joint effort of Midwest Medical Insurance Company and the Iowa Medical Society. The first step in establishing the program is to find Iowa physicians in all specialties who are willing to offer assistance, information and emotional support to colleagues who are being sued. A half-day training session will be required. Contact Lori Atkinson with MMIC, 515/223-1482 or 800/798-9870 if you are interested in hearing more about becoming a physician volunteer. The Physician Litigation Support Program will be available to all IMS members sometime in June of this year.

●**AS OF PRESS TIME,** the IMS was experiencing some technical difficulties with the server which hosts our web site. These problems are temporary . . . keep trying! Check out http://www.IowaMedicalSociety.org for valuable and current information geared for Iowa physicians.

●**A PRELIMINARY INJUNCTION HAS BEEN ISSUED** in federal court which delays Iowa's new law requiring that parents be notified before an abortion on a pregnant minor. In response to a lawsuit brought by several organizations, Judge Ronald Longstaff issued the order on January 22 further delaying implementation of the notification requirements of the law. The legislature may choose to address the court's constitutional concerns by modifying the law this legislative session. However, physicians should note that some provisions will go into effect, including the requirement that physicians providing prenatal care to minors offer the viewing of a video designed to assist the minor in choosing between adoption, keeping the baby or abortion. This part of the law was not challenged in the lawsuit.

●**THE 1997 IMS MEDICINE DAY AT THE CAPITOL** is set for Wednesday, February 26. This event will help physicians, Alliance members and clinic managers understand the legislative process and view a working day at the Capitol. The day will begin with a program and lunch at IMS headquarters beginning at 11:45 a.m. Guest luncheon speaker will be Dr. John Redwine of Sioux City. A bus will then transport you to the Capitol. To register or for more information, send us e-mail through the IMS web site at http://www.IowaMedicalSociety.org or call Cheryl Peers at 800/747-3070. Registration deadline is Friday, February 21.

●**AFTER A NATIONAL INSTITUTES OF HEALTH PANEL** issued a report stating that it did not find sufficient evidence to support screening mammography for women age 40-49, the American College of Radiology was quick to issue a press release reaffirming its support for the screening test for women in their 40s. The ACR cites two independent studies showing a statistically significant decrease in the breast cancer death rate of 44% and 36% respectively for women who began screening in their 40s. The NIH decision caused much controversy among women's groups and health care providers.

●**PRESIDENT CLINTON HAS RELEASED** preliminary information on his plan to cut $138 billion from Medicare spending over the next six years. According to the *Washington Post*, the president's plan relies heavily on cuts in reimbursement to hospitals, HMOs, home health agencies, skilled nursing homes and (to a lesser degree), physicians who treat Medicare patients. Details will be contained in the president's budget, to be released this month.

For more information about any *DEADLINE* news item, call Chris McMahon at IMS headquarters, 515/223-1401 or 800/747-3070.

Iowa Medicine

JOURNAL OF THE IOWA MEDICAL SOCIETY FEBRUARY 1997 / VOLUME 87 / 2

You won't want to miss the 1997 IMS Scientific Session & Annual Meeting. This revamped April 18-20 weekend will include hands-on Internet training, a Q & A on the Virtual Hospital, featured speakers on technological advances in medicine and clinical controversies. Call the IMS or send an e-mail message to Cheri Jensen at imsadm@netins.net to register.

FEATURE ARTICLES

Golden days are ahead of us 49

Don't step back from the plate on the issue of greed vs. quality.
WILLIAM MCMILLAN, MD, IMS PRESIDENT

New on the Net 51

This column will keep you up to date on how to make the Internet work for you and your practice and what's new on the IMS web site. Manage your finances on the web; hot sites.

Managed Care . . . News you can use 53

Patient satisfaction continually assessed at Cedar Valley Medical Clinic (seventh in a series).

Current Issues 55

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Friendship Providers, Inc. 65

On the lighter side . . . would your friends quality as Friendship Providers?

Managing the transition 66

How to manage the medical loss ratio and other advice for physician organizations.
JACQUE SOKOLOV, MD

Current therapy of Parkinson's disease 71

Part 2 of a two-part article on the role of medication, surgery and diet in treating Parkinson's disease. *TODD AJAX, MD; ROBERT RODNITZKY, MD; JUDITH DOBSON, RN*

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No front-load: misnomer or misleading? *JERRY FOSTER* 69

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Golden days are ahead of us

Sitting in the surgeon's lounge, a curiously infectious conversation keeps coming up. The old guys affectionately call it the "golden years" discussion. Because of the changes in medicine, middle-aged medics (already with pension plans) contemplate early retirement. The new guys commiserate over managed care then refuse to be businessmen, even avoiding a decision on how much to charge. All these doctors avoid the greed vs. quality debate. If value decisions are left to managers who have more interest in stock prices than community health, should we be surprised when excessive corporate profits come out of the hides of our patients as we hide behind the plea "just let me practice medicine"?

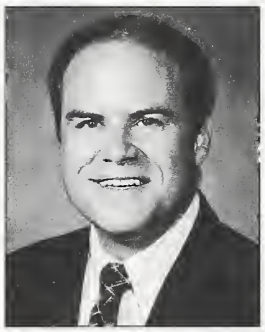
What qualities of a physician set him apart from a "surrogate provider" now so popular with managed care plans? Is 10-15 years of education a good investment when we practice according to protocols and the common solution to decreasing revenues is more patients and less time? Let me suggest our patients get less comprehensive care and less compassionate care because we refuse to expand our definition of providing that care. The answer involves taking greed out of the practice of medicine. The answer is to give more of ourselves and our time. The answer means scrupulously examining every care decision to assure patient welfare over self inurement. If industries within medicine sacrifice long-term quality for quick profits, we need to stand up and say "no". If managed care creates decreased or over-priced access, we need to be our patients' advocate and refuse compromise.

The essence of a profession is its ability to decide its own destiny. If we step back from the plate on the issue of greed vs. quality we will lose the patient trust which makes us effective healers.

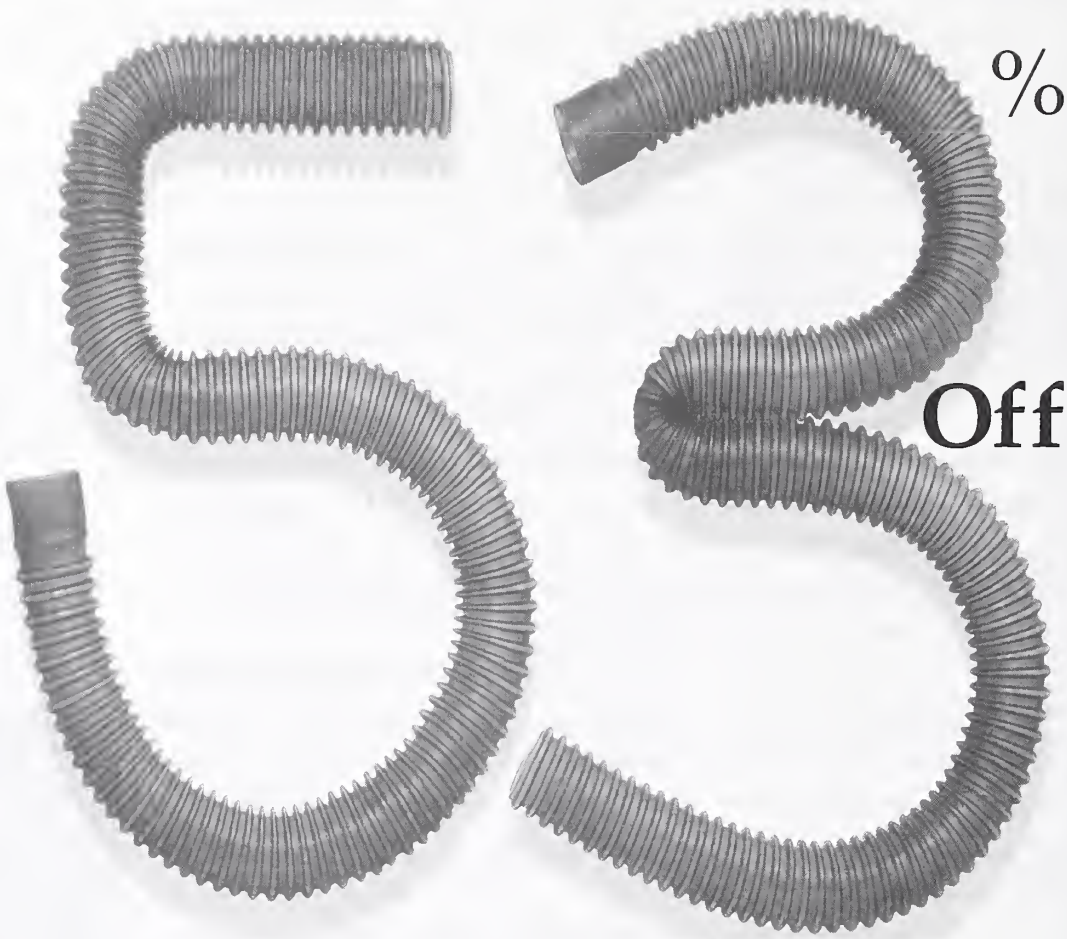
So become a full-time partner with your office manager to stand for ethical practice. Understand the public health providers and how a partnership with them will promote community health. Decry the sacrifice of quality for profit, including gouging done under the guise of cost shifting. Remember, we learn the humanities before medical skills. Only through the responsible application of that humanity can our profession answer today's health care needs.

If we step back from the plate on the issue of greed vs. quality, we will lose the patient trust which makes us effective healers.

Doctors need to work together guided by our core values to solve the ethical and professional problems with managed care and reduced government support. We need a culture of ownership of our practice and of our patient's health. If we treat our patient as our best friend and not our best customer, I believe the golden age of medicine is ahead of us. IM

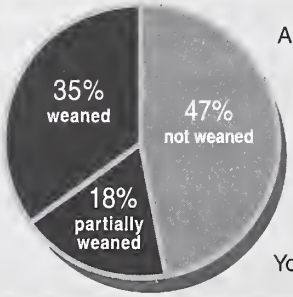


William McMillan, MD
IMS President



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New on the Net

Manage your finances on the Internet

Whether you are looking to finance some new office equipment or simply want to check up on your stock investments, you'll find some simple web finance tools to make the Internet work for you and your practice.

Wanting to finance some new office equipment or figure out how much to save for your retirement? Try FinanCenter's nearly two dozen financial calculators. Its budget calculators can even help you figure out a sensible spending plan for your home or business. *http://www.financenter.com*

Check your stock investments by creating a personal page on the Quicken Financial Network site. Each time you log into the site you'll find links to news headlines about topics you're interested in and price quotes for your investments which are updated every 15 minutes. *http://www.qfn.com/index.html*

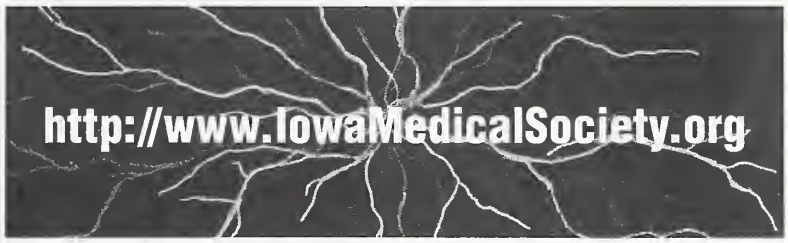
See the IMS Internet Hints feature on the IMS web site for more suggestions and quick web links for managing your finances.

Start with the IMS web site

It's easy to configure your web browser to start with the IMS web site each time you use the Internet. Simply follow the instructions for your browser, and you will be set to start-up with the IMS web site.

Netscape Navigator: Launch Navigator and choose *General Preferences* from the *Options* menu. Click on the *Appearance* tab. Choose the second radio button under the *Start With* section of the window to designate a specific home page location. Enter the IMS web site address into the adjacent entry box. *http://www.iowamedicalsociety.org*

Microsoft Internet Explorer: Launch Explorer and open the IMS home page. Choose *Options* from the *View* menu. Click on the *Start Page* tab and choose *Use Current* button.



Linking IMS physicians to the information they need

Hot sites

Active individuals: While the Physician and Sportsmedicine web site regularly covers sportsmedicine topics such as diagnosing and treating athletic injuries, most of this site's information is practical, primary-care information for the care of active people. This site is attractive and fast, with great information and quick "pearls" of advice from other physicians. *http://www.physsportsmed.com*

Web expeditions: If you're new to the Internet, make the web expeditions from the *Washington Post* one of your first stops. Even if you're a web expert, you'll find these tours helpful in sorting through the millions of sites on the Internet by topics such as tax tools, unusual gifts and vacation planning. *http://www.washingtonpost.com/wp-srv/interact/longterm/safari/safari.htm*

Laugher is the best medicine: The AOL Doctor's Page stands by this motto with its medical humor directory to jokes, anecdotes and cartoons. *http://members.aol.com/DrsPage/humor.htm*

Patient education: Use Medweb's consumer health pages to download articles for patients about conditions from AIDS to diabetes to urinary tract infections. *http://www.gen.emory.edu/medweb/medweb.consumer.html* IM

IMS staff members are on the watch for sites that might interest Iowa physicians. Staff members visit all **Hot sites** *to make sure they have useful information and reasonable download times. Suggestions for* **Hot sites** *can be sent to Melanie Finke by e-mail at communic@netins.net or by telephone at 800/747-3070.*

Throckmorton Surgical Society
Iowa Chapter - American College of Surgeons
Iowa Academy of Surgery

SPRING MEETING - May 2 - 3, 1997

Guest Faculty

Blake Cady, M.D.
Professor of Surgery
Harvard Medical School
Boston, Massachusetts

Richard E. Fine, M.D
The Breast Center
Marietta, Georgia

Armando E. Giuliano, M.D.
Clinical Professor of Surgery
UCLA Medical Center
Director, Joyce Eisenberg Keefer
Breast Center
John Wayne Cancer Institute of
St. John's Health Center
Santa Monica, California

Roger D. Gingrich, M.D.
Professor, Internal Medicine
The University of Iowa
Iowa City, Iowa

Donald W. Moorman, M.D.
Director, Surgery Education
Director, Surgical Division
Human Gene Therapy Research Institute
Iowa Health System
Des Moines, Iowa

Edgar D. Staren, M.D, Ph.D.
Associate Professor of Surgery
Rush Presbyterian-St. Luke's Medical Center
Chicago, Illinois

John Forsyth
President and CEO
Blue Cross & Blue Shield of Iowa

Thomas M. Foley, M.D.
Chairperson
Iowa State Committee on Trauma

Olga Jonasson, M.D.
Director of Education and
Surgical Services Department
American College of Surgeons

Samuel T. Wallace
President
Iowa Health System
Des Moines, Iowa

Topics

May 2, 1997

No need for axillary dissection - Modifications of traditional therapy as a result of declining size from mammographic screening - Locally advanced breast cancer - Stereotactic guided percutaneous biopsy - Comparison of stereotactic and ultrasound guided percutaneous breast biopsy - Bone marrow transplant - Sentinel lymphadenectomy staging of breast cancer - Technical aspects of sentinel lymphadenectomy - Genetics of breast cancer - Breast ultrasonography for the surgeon, by the surgeon: Physics, principles and instrumentation for normal breast ultrasound - Diagnostic and interventional breast ultrasound

May 3, 1997

Morning Session:
Health systems of the future - Partnering with physicians - Update of Iowa's trauma system - Education of a surgeon

Afternoon Session:
Presentation of surgery resident competition award papers - Presentation of papers by members of Iowa Academy of Surgery (topics TBA)

Accreditation

As an organization accredited for continuing medical education, the Iowa Methodist Medical Center certifies that this offering meets the criteria for Category I credit toward AMA Physicians' Recognition Award, provided it is used and completed as designed.

Friday, May 2, 1997:	7 hours
Saturday, May 3, 1997:	TBA

Cost

Physician fee.	$ 150.00
Resident fee.	$ 35.00

Contact:

Department of Surgery Education (515) 241-4076
Iowa Methodist Medical Center
1221 Pleasant Street, Suite 550
Des Moines, IA 50309

Patients' needs top priority for Waterloo group

(Seventh in a series)

Cedar Valley Medical Clinic, PC of Waterloo is made up of 41 physicians representing 11 specialties. According to CEO Gil Irey, a group of specialists decided to organize after witnessing primary care physicians forming groups with hospitals in managed care organizations.

"Specialists were seeing that they would be better off to organize themselves. The marketplace really convinced them to form this group," explains Mr. Irey. In 1994, this multispecialty group without primary care was organized.

Physician-directed organization

The physician shareholders of Cedar Valley Medical Clinic direct the organization by electing a nine-member board of directors from the shareholders. The board, with general membership input, makes decisions for the clinic.

Dr. Steve Davis, president of the clinic and full-time general surgeon, describes his role as "coordinator and organizer of physician talent". He reviews and defines issues, then gets physicians with the interest and expertise in specific areas.

As chief executive officer, Mr. Irey provides input and information into the decision-making process, then implements decisions made by the board.

Advantages for physicians

A physician-directed group has a number of advantages. There is opportunity for individual physician input, yet the clinic is large enough to help define the delivery of health care services in the seven-county area around Waterloo. Mr. Irey cites another advantage of a physician-directed organization: physicians can have some direction and control of their future by being involved with payers and providers as health care programs are being redesigned.

Goals include identifying patients' needs

In the years to come, Cedar Valley Medical Clinic will continue to build on the success it has enjoyed in the past. The group works hard to identify patients' needs and provide the highest quality specialty care. As Dr. Davis explains it, "We are a supplier to the process of health care delivery. And as suppliers, we have to identify our customers and find out what their needs and requirements are and provide services according to those requirements. This represents a tremendous process improvement for the medical community of Waterloo."

The clinic also is looking for ways to provide services currently not available, through recruiting new physicians and cooperation with other health care providers in the area.

What to do before you organize a group

Dr. Davis and Mr. Irey share their expertise and advice for Iowa physicians considering organizing a group:

1) Obtain a definite commitment to common goals and develop an organizational structure to support those goals.

2) Seek out one or two successful models and learn from them.

3) Design a governance structure in the beginning so when the group begins operation it isn't dealing with how to organize.

4) Build a solid management/organizational structure with committed physician leadership. IM

"Seek out one or two successful models and learn from them."

KEY CONTACTS:

Cedar Valley Medical Clinic, PC
319/235-5390

Steve Davis, MD
President

Gil Irey
CEO

If you know of other innovative practice arrangements we should write about in Iowa Medicine *— especially those controlled by physicians and positioned to compete in the managed care market — call Barb Cannon or Chris McMahon at the IMS, 515/223-1401 or 800/747-3070.*

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At **Dale Clark Prosthetics**, our philosophy is simple: provide each patient with the best possible prosthetic and orthotic care for the best possible outcome.

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IMS Services
Upcoming Seminars

THESE PROGRAMS ARE PART OF THE IMS MEDICAL BUSINESS SPECIALIST (MBS) CERTIFICATE PROGRAM.

Resource Management

March 18
Mason City, Iowa
North Iowa Mercy Medical Center, West Campus #7

April 3
Sioux City, Iowa
St. Luke's Regional Medical Center, Room 1

This workshop is designed to provide information about accounting, tax and human resource issues. The session will feature financial aspects of basic accounting, reading and understanding financial statements, payroll tax reporting, cost controls and planning for growth. Human resource issues include ADA, FMLA, interviewing, performance measures and compensation.

Seminar time is 9:00 a.m. to 4:00 p.m. Lunch will be provided.

Instructors from Vroman, McGowen, Hurst, Clark & Smith, PC., Certified Public Accountants and Business Advisors.

CPT Coding

March 27
West Des Moines, Iowa
IMS Headquarters
Taylor Room

With the current emphasis on post-payment review, audits and revenue analysis, you need to use the CPT Coding system properly.

This seminar is an overview of the design and use of the AMA's CPT book. It will cover the outline of the coding system, coding conventions, guidelines for choosing codes appropriately, correct use of modifiers, common coding errors and questions. Application exercises and case studies will be included.

Please bring a 1997 CPT book.

Seminar time is 9:00 a.m. to 4:00 p.m. Lunch will be provided.

Instructor: Barbara Cannon, Iowa Medical Society.

Quality in the Medical Office

April 1
West Des Moines, Iowa
IMS Headquarters
Taylor Room

April 17
Davenport, Iowa
St. Ambrose, Professional Development Center

Since outcome measures are the wave of the future, understanding the quality process is critical in today's medical office.

This course examines, trends in quality, i.e., total quality, outcome measures, practice parameters and patient satisfaction results.

Seminar times ar 9:00 a.m. to 4:00 p.m. Lunch will be provided.

Instructor: Mary Pat Wohlford-Wessels, University of Osteopathic Medicine and Health Sciences.

Cost: $99 for IMS member or staff/$198 for nonmember (includes lunch)

TO REGISTER SEE REVERSE SIDE

REGISTRATION FORM

Complete this form and mail it along with your check or money order to:

IMS Services
Attn: Seminars
1001 Grand Avenue
West Des Moines, Iowa 50265-3599

NAME(S) _____

OFFICE/CLINIC _____

ADDRESS _____

TELEPHONE _____ FAX _____

SEMINAR: CPT Coding

____ March 27, West Des Moines

Quality in the Medical Office

____ April 1, West Des Moines ____ April 17, Davenport

Resource Management

____ March 18, Mason City ____ April 3, Sioux City

Are you or is your physician an IMS member? YES NO

Are you in the MBS Certificate Program? YES NO

Payment Method:

Check or money order made payable to IMS Services Amount Enclosed _____

Credit Card (circle one): MasterCard
VISA
American Express

Credit Card number: _____

Expiration date: _____

Cost: $99 for IMS member or staff/$198 for nonmember (includes lunch)

MS Update

edical informatics and managed care

Practicing physicians won't want to miss e Iowa Medical Society's 1997 Scientific ssion "A Journey into Cyberspace" Friday, ril 18 at the Embassy Suites, Des Moines.

The majority of the day will be devoted to chnological advances in medicine. Phyian experts from the University of Iowa will scuss the latest in electronic medical cords and telemedicine's impact on medical



ractice in Iowa. Jeffrey Galvin, MD, UI epartment of Radiology professor, is sched-ed to discuss the University of Iowa's irtual Hospital.

Physicians who want to check out the ealth of information available on the ternet won't be disappointed. Training on e Internet, e-mail and CD rom will run con-

News at a glance

One of the most controversial issues at the AMA Interim Meeting December 7-11 was partial birth abortion. Two resolutions to ban the practice were introduced and as a result of the ensuing debate, the AMA House reaffirmed the AMA's abortion policy. The policy states that termination of pregnancy is a medical matter between the patient and physician. The House also requested a study of late term pregnancy termination techniques.

The Iowa Department of Public Health has issued a report on "Drug Use in Pregnancy: A Study of Prevalence in Iowa". If you would like a copy of the report, call 515/281-3641 or fax your request to 515/281-4535.

currently with the day-long session and will be available throughout the weekend. Staff from the University of Iowa Hardin Library and the IMS will be available to help physicians become experienced surfers and to offer hands-on demonstrations of multimedia software and other diverse technologies.

The keynote speaker for the Scientific Session is Dr. Jacque Sokolov. Dr. Sokolov is a nationally recognized expert in health delivery systems and runs a consultant firm whose clients include 40 physician groups and 15 Blue Cross Blue Shield plans. Dr.

continued

News from Iowa Medical Group Management Association (IMGMA)

Administrators hired to guide practices to profitable future

In recognition of the important function that the office manager and administrator play in the success of any medical practice, the Iowa Medical Society established the Administrator of the Year Award. The award has been given annually since 1991 to an administrator/office manager who has been nominated by an IMS member physician. Criteria for the award includes job accomplishments, community involvement and honors received.

The current climate finds office managers increasingly having to mold themselves to accommodate changing job demands. Practices are now forming a tiered level of management, including an administrator and an operations manager. The operations manager becomes the front line in running daily operations and managing the workforce. The skills of an office manager are vital to the smooth operation of any physician practice, however, the additional skills and experience an administrator offers, such as negotiating new contracts, developing practice concepts and increasing revenues, can make a practice truly successful in today's changing medical field.

To submit someone for consideration as the IMS Administrator of the Year, call or write Dana Petrowsky, IMGMA, 1001 Grand Avenue, West Des Moines, Iowa 50265, 515/223-2816 or 800/728-5398. Deadline is March 1, 1997.

IMS Update

continued

Sokolov's presentation will be "Advanced Health Plans, Performance-Based Integrated Delivery Networks and Optimal Physician Organizations".

Dr. Sokolov was a speaker at a meeting of the Iowa Medical Group Management Association last year and got excellent reviews. An excerpt from his presentation can be found on page 66 of this issue.

Disease management strategies and clinical controversies in stroke management, osteoporosis and obesity management are also on the agenda. A complete program will be mailed to all IMS members in early March.

The 1997 Scientific Session is being held in conjunction with the annual House of Delegates meeting, also at the Embassy Suites. The IMS House of Delegates will meet Saturday morning, April 19 and Sunday morning, April 20. Election of officers will be Sunday morning. (See the following story.)

IMS offices up for election

Election of 1997-98 IMS officers will take place during the House of Delegates meeting Sunday morning, April 20.

Physicians have until the March 9 meeting of the nominating committe to declare the intention to seek an office.

Offices open for election include: president-elect, trustee, vice president, House speaker and vice speaker, two AMA delegate slots, two alternate AMA delegate slots and councilors in Districts 3, 7, 8, 12 and 15.

If you are interested in running for an IMS office, contact Sandy Nelson at the IMS, 515/223-1401 or 800/747-3070. IM

Focus on IMS Alliance

Welcome, Mike Abrams!

We're very pleased to report that Mike Abrams, IMS executive vice president and a former Indiana Alliance member, is our newest IMSA member. When approached about being a member he replied, "I wouldn't consider not joining." His dues are paid . . . he's one of us. Welcome to Iowa and the Alliance.

Specialty Society Update

Denise Chaffee, regional manager of Mercy Physician Services in Cedar Rapids, is the new 1997 Iowa Medical Group Management Association president. According to IMGMA records, there was an unusually high turnover rate in the office management employment situation in Iowa in 1996.

At the Iowa Academy of Otolarngology (IAO) membership meeting in December, James Spoden, MD was appointed the IAO representative to the IMS House of Delegates on April 19-20, 1997 at the Embassy Suites in Des Moines. Thomas Benda, Jr., MD was reappointed to the Carrier Advisory Committee. Other issues discussed at the meeting include third party relations, Medicare audits and guidelines for comprehensive physical exams and creation of a newsletter.

Iowa Oncology Society officers elected for 1997 and 1998 are: president, Dean Gesme, Jr., MD; vice president, John Okerbloom, MD; secretary/treasurer, Larry Otteman, MD and board members (1-year term), Walter Bate, MD; Susan Kambhu, MD; Roger Gingrich, MD and Roscoe Morton, MD.

For more information, contact Dana Petrowsky or Dave Furneaux at 515/223-2816 or 800/728-5398.

Obstetrician/Gynecologist . . .

There is an immediate opening at Brainerd Medical Center for an Obstetrician/Gynecologist.

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- Great community for families

Call collect to Administrator:
Curt Nielsen
218/828-7105 or 218/829-4901
2024 South 6th Street
Brainerd, Minnesota 56401

Legislative Affairs

Parental notification/decision-making video

Physicians providing pregnancy-related care to a pregnant minor will still be required to offer viewing of a video designed to help the minor make decisions about the pregnancy, in spite of a recent court ruling delaying part of the new parental notification of abortion law. The video must be offered whether or not the minor is considering abortion. The video and accompanying materials have been prepared by the Iowa Department of Public Health and will be mailed to all obstetricians, family physicians and pediatricians free of charge. They will be provided to other physicians upon request. This portion of the law will not be enforced until physicians have received the materials. The IDPH plans to mail them in early February.

Physicians are not required to ensure that the minor actually views the video, but the offer must be made and documented in the medical record.

The portion of the new law requiring that parents be notified before an abortion is performed on a minor has been temporarily delayed by a recent federal court decision. Judge Ronald Longstaff of the U. S. District Court, Southern District of Iowa ordered a temporary restraining order against portions of the law, pending resolution of constitutional issues. The order delays implementation of the parental notification requirements but leaves standing the requirement that physicians must offer viewing of a video to pregnant minors. The judge is expected to rule on a request for a permanent injunction against enforcement of the parental notification requirements in the near future.

This issue has been fraught with controversy throughout its legislative history. Legislators are expected to modify the law to try to resolve some of the constitutional issues that have been raised through the court case. For an update or copies of the rules implementing this law, call Becky Roorda at the IMS.

News at a glance

Physicians and physician spouses who ran for national office made an impressive showing in the November 5 election. Of the 30 doctors and spouses who vied for congressional seats, at least 11 were elected. Medicine's candidates at the state level also fared well, led by the reelection of Howard Dean, MD as Vermont governor.

The AMA filed an amicus brief with the U.S. Supreme Court maintaining there is no constitutional right to physician-assisted suicide. The Supreme Court heard testimony on the issue in early January. At issue are two recent appeals court rulings which have been interpreted to open the door on assisted suicide. A ruling is expected in June.

Civil Justice Reform Act of 1997

One of the top priorities of the 1997 session for the IMS is passage of the Civil Justice Reform Act of 1997. The IMS is working with a coalition of tort reform advocates seeking much needed reforms of the state's civil justice system. The bill is being called the Civil Justice Reform Act of 1997: A Dozen Common Sense Improvements to the Civil Justice System.

The bill contains a $250,000 cap on noneconomic damages applicable to all types of cases, a reduction in the statute of limitations for minors in medical malpractice cases, tightening of the expert witness standards, a statute of repose for products and several other issues of concern to the business community.

The coalition is broad-based. In addition to the IMS, members include the Iowa Osteopathic Medical Association, the Association of Hospitals and Health Systems, the Association of Business and Industry, groups representing accountants, architects, general contractors, realtors, automobile dealers, truck-

continued

Legislative Affairs
continued

ing companies and many more.

Physicians are encouraged to discuss the need for comprehensive tort reforms with their legislators. Attend town meetings, bring the issue up at meetings of community organizations or set up a special community meeting to discuss the issue with local legislators. For information or assistance call Becky Roorda at the IMS. IM

CONTACTING YOUR LEGISLATORS

Telephone numbers during the session:

Senators	**515/281-3371**
Representatives	**515/281-3221**
Governor	**515/281-5211**

Write to them at: STATEHOUSE
Des Moines, Iowa 50319

You may also contact your legislators at home when the legislature is not in session. If you don't know who your legislator is or need your legislator's home address and phone number, call Cheryl Peers of the IMS staff, 800/747-3070 or 515/223-1401 (or e-mail legis@netins.net). You may access the Iowa Statehouse web site at www.legis.state.ia.us.

Neurologist & Oncologist . . .

There are immediate openings at Brainerd Medical Center for a Neurologist and an Oncologist.

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Curt Nielsen
218/828-7105 or 218/829-4901
2024 South 6th Street
Brainerd, Minnesota 56401

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Medical Economics

Regulation task force completes work

The Health Regulation Task Force, which has met monthly since last June, has completed its work and made recommendations on ways to streamline the regulation of the health care industry in Iowa.

The Task Force was appointed at the request of Governor Branstad. Representing the IMS on the Task Force were Jeff Anderson, MD, Des Moines and Steven Wolfe, MD, Spencer. Recommendations of the task force will likely be implemented through the legislature or the administrative rules procedure.

Among the group's recommendations are:

•Keep the Certificate of Need process but make changes in the CON law. These include raising the capital and equipment thresholds.

•Develop a process to provide information on proposals to expand scope of practice, license new professions or resolve disagreements between health professionals examining boards over licensure or regulatory issues. Ad hoc committees would develop recommendations which would then go to the legislature.

•Level the playing field so that any entity in health care which is bearing financial risk (ODS, HMO, PPO, etc.) would be regulated according to similar rules. This can be accomplished through the administrative rules procedure without legislation. However, it is recommended that legislation be sought which would allow limited benefit managed care entities in Iowa (i.e., prescription drug, vision care, etc.).

Copies of the full report are available from the IMS.

Idea of Medicare commission loses steam

Special interest groups and congressional Republicans are exhibiting little interest in an appointed commission to examine the long-term solvency of the Medicare program.

Before the election, both President Clinton and Bob Dole supported the idea. However, many Republicans believe they lost several House seats due to Democratic attacks on Medicare and are now unwilling to give the President an "easy road on Medicare reform", reports a recent issue of *Modern Healthcare.*

An AMA spokesman said reforming Medicare will require "tough decisions and, if structured right a commission would be all right. But, we already know what has to be done. Political decisions have to be made and we need to get on with it right away."

The AMA has formulated its own proposal for restructuring the Medicare program and plans to push the proposal during the 1997 congressional session.

Meanwhile, the *Kiplinger Newsletter* speculates that politicians aren't ready yet for a long-lasting Medicare fix which could require unpleasant solutions such as means testing or raising the age of eligibility.

A major overhaul of Medicaid will also be put off, says *Kiplinger.* IM

News at a glance

Blue Cross Blue Shield of Iowa will pay $14.6 million to settle three class action lawsuits filed over billing practices. According to a Des Moines Register *article, thousands of policyholders will get payments for medical bills they paid between 1992 and 1996. At issue was how the insurer calculated co-insurance payments.*

The average Medicare payout per recipient per month in Iowa's 99 counties is considerably below the national average. Nationally, Medicare spends $467 per recipient each month. The figures for nearly all counties in Iowa are well below the national average; in seven Iowa counties, the figure is at least 40% below the national average. Those counties are: Allamakee, Decatur, Greene, Marshall, Osceola, Sac and Winnebago.

DATA & TECHNOLOGY

Is your computer ready for 2000?

Many computers only recognize two digits in the year field. In the year 2000, the computer will be unable to distinguish if a person born in "00" is 100 years old or a newborn. Appointment schedulers, aging reports, comparative financial reviews — virtually anything that ties back to the date — could be affected.

Some estimate the problem will affect nearly 80% of health care providers. Physicians should review how their computers store the date — obviously the full four digits will be necessary. Ask your computer vendor for assistance. But don't delay — 2000 is less than three years away. The correction to accommodate four digits in the year field could affect every software program on your computer and could be a time consuming task to rectify.

Physician use of EDI lagging

According to Faulkner & Gray's *1997 Health Data Directory*, 56% of health care claims were transmitted to payers electronically in 1996, up from 51% in 1995. Pharmacies lead providers in electronic data interchange (EDI) of insurance claims, sending 83% electronically; hospitals send 82% of insurance claims using EDI. Physicians use EDI only 35% of the time but are showing significant increases in recent years. In 1995, 27% of physicians used EDI for submission of insurance claims; the figure was 18% in 1994.

This increase by physicians is partly attributed to the formation of large group practices. As provider organizations get larger, there is more efficiency in automation. But even small provider groups can realize savings through the use of EDI. Most software for electronic claim submission performs some edits to ensure the claim contains all required information before passing the claim onto the payer. Rejected claims are returned immediately with explanations, while clean claims should get paid faster.

Transactions fees charged by clearinghouses mostly remained steady throughout 1996. In fact, many insurance companies and managed care plans are connecting directly to clearinghouses and paying the fees so providers don't have to.

Electronic prescriptions

Perhaps the next major advance in electronic processing for physicians will be electronic transmission of prescriptions to pharmacies. Many large software firms, including IBM, have either launched software that links doctors and pharmacies, or will soon introduce it.

Physicians already using the software are finding many advantages. Patient drug histories are readily available which helps avoid drug interactions. Drug formularies for different health care plans can be entered into the software, prompting the physician about plan benefits and restrictions, such as the use of generic drugs. Electronic prescriptions eliminate illegible handwriting, cross-check dosages, transmit diagnosis information more frequently requested by pharmacists and provide a mechanism for the pharmacist to inform the physician that the prescription was picked up by the patient.

Another big payoff will come when such software can improve compliance with disease management guidelines and provide data to support outcomes studies on pharmaceuticals and their effect on patients. IM

HBO & Co. (HBOC), a leading health care software company, has recently acquired GMIS, Inc. GMIS is the software being tested by Iowa's Medicare fiscal intermediary, Blue Cross and Blue Shield of Iowa, to detect duplicate or fraudulent claims. HBOC provides software for practice management and electronic medical records. This acquisition strengthens its position in the payer software market.

For more information, call Ed Whitver, IMS manager of health care data and technology, 515/223-1401 or 800/747-3070.

Practice Management

MBS program going strong

The Medical Business Specialist program has four new graduates, bringing the total number of graduates to 22. Since the program's inception in 1994, 95 people have participated in the MBS program.

Pictured below are Jodi Privoznik and Randi Stover. Two other graduates, Connie McDermott and Kathy McGee, are pictured on page 62.

continued

News at a glance

A Lincoln Nebraska family practice program keeps managed care notebooks at all nurses stations for the five faculty and 21 residents. The three-ring binders outline the practice's managed care contracts, contact names and phone numbers for all the plans, referral panels for each plan, hospitals covered and contacts at the hospitals, what's covered and what's not by each plan. The family practice program business manager says the notebooks have saved him lots of time answering questions from physicians and staff.

The Internet may be experiencing growing pains, but it clearly is here to stay. Some clinics reportedly are letting patients schedule appointments through the clinic web site.



Jodi Privoznik



Randi Stover

Practice Management Workshops for You

Resource Management

March 18 — **North Iowa Mercy Medical Center, Mason City**

April 3 — **St. Luke's Regional Medical Center, Sioux City**

Accounting, tax and human resource information. Instructors from Vroman, McGowen, Hurst, Clark & Smith, PC.

CPT Coding

March 27 — **IMS Headquarters, West Des Moines**

An overview of the design and use of the AMA's CPT book covering the coding system, coding conventions, guidelines for code usage and common coding errors. Instructor: Barbara Cannon.

Quality in the Medical Office

April 1 — **IMS Headquarters, West Des Moines**

April 17 — **St. Ambrose, Davenport**

Examines trends in quality, i.e., total quality, outcome measures, practice parameters and patient satisfaction results. Instructor: Mary Pat Wohlford-Wessels.

For more information or to register for any IMS practice management workshop, call Sherry Johnson at IMS Services, 515/223-2816 or 800/728-5398.

Practice Management

continued

Midwest Medical Insurance Company Focus on Risk Management

Problems with medical records: untimely notes

The quality of medical records is a critical factor in efforts to prevent and control patient injuries and malpractice losses. Untimely documentation can have significant consequences. Many patient injuries occur because of missing and untimely documentation that precludes physicians and other health care providers from rendering appropriate treatment. An injury that occurs because information has not yet been entered in the patient's chart is likely to be indefensible. In one case, a physician examined a patient complaining of chest pain and nausea late on a Friday afternoon. He suspected an evolving ischemia and decided to wait and watch her for a week. He then left on vacation, planning to dictate that afternoon's notes when he returned in two weeks. One week later, the patient returned to the office with the same complaints. A covering partner examined her and also suspected an evolving ischemia. He too elected to wait and watch her, not knowing of his partner's suspicions a week earlier. She died several days later of an acute MI.

Any dictation completed after a complication has occurred will appear self-serving and lack credibility, even if the care rendered was entirely appropriate. In one case, a physician neglected to dictate an operative report. This was brought to his attention weeks later. Not recalling that he had encountered significant problems during the procedure, he instructed his transcriptionist to type his usual "canned" operative note. The patient later filed a malpractice claim alleging the complications she suffered were a result of the physician's negligence. It was difficult for the physician to explain the short, routine operative note while also claiming that the complications were a result of an extremely difficult surgery and not negligence on his part.

For more information contact Lori Atkinson, MMIC risk management supervisor, Midwest Medical Insurance Company, West Des Moines Office, PO Box 65790, West Des Moines, Iowa 50265; 800/798-9870 or 515/223-1482.

Jodi Privoznik, insurance specialist with Cardiovascular Medicine, PC in Davenport, received her MBS plaque in November, 1996 at a special staff recognition ceremony.

Randi Stover, secretary and transcriptionist for Dr. Chad Abernathy in Cedar Rapids, completed her MBS requirements in October, 1996.

Connie McDermott and Kathy McGee received their MBS certification in October, 1996. Ms. McDermott is the business office manager at Shelby County Medical Clinic in Harlan. Ms. McGee is the office manager at Forest Park Psychiatry, PC in Mason City. IM



Connie McDermott (left) and Kathy McGee

Clarkson Medical Lecture Series

"Nephrology Update"
Management of Acute Renal Failure

May 2, 1997
8 a.m. to 4 p.m.

Clarkson Hospital
Omaha, NE
Storz Pavilion

For more information, call
402.552.3377

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e-mail: memserv@netins.net

Newsmakers

News at a glance

Dr. Bery Engebretsen, Des Moines family practitioner, has been listed in the positive Physician Honor Roll in the book, 50 Most Powerful Doctors in America.

Three pediatricians from the Davenport area were recently named in the book, The Best Doctors in America: Central Region, 1996-97. *Drs. Robert Anderson, Barry Barudin and Greg Garvin were cited for their "superior clinical abilities" in general pediatrics. The book recognizes physicians in communities of all sizes throughout the central region and is based on a survey of 5,000 physicians.*

Awards, appointments, etc.

Dr. Harold Adams, professor of neurology at the UI College of Medicine, is one of six UI faculty members to win the State Board of Regents Faculty Excellence Award. Two UI College of Medicine faculty were recently honored for their dedication to teaching and service. **Dr. G. Edgar Folk, Jr.**, professor emeritus of physiology and biophysics, is the the first recipient of the Dr. John P. Long Teaching Award in the Basic Sciences. The award honors Dr. Long, professor of pharmacology, for his long-standing service and dedication to medical education. **Dr. Robert Soper**, professor of surgery, is the recipient of the Dr. Ernest O. Theilen Clinical Teaching and Service Award. Established in 1991, the award honors Dr. Theilen, who was professor and associate chairman for clinical programs in the Department of Internal Medicine until his death in 1991. Other award winners at the UI College of Medicine include **Drs. Bradley Doebbeling, George Lawry, Richard Kerber** and **Curt Sigmund.** Drs. Doebbeling and Lawry, assistant professors of internal medicine, recently won Collegiate Teaching Awards from the UI Council on Teaching. Dr. Kerber, professor of internal medicine, received the Award of Meritorious Achievement from the American Heart Association in recognition of his efforts to advance the Association's national programs. Dr. Sigmund, assistant professor of internal medicine and physiology and biophysics, was awarded the Henry Christian Award for Excellence in Clinical Research by the American Federation for Clinical Research. The award recognizes his study of molecular genetics and genetic links to hypertension. **Dr. Lisa Brothers Arbisser**, of Eye Surgeons Associates in Davenport, has been renominated to the board of directors for the American College of Eye Surgeons. Dr. Arbisser has served on the board since 1994. **Dr. Nicholas Shammas**, Davenport, has been elected a fellow to the American College of Cardiology.



Dr. Clarence Denser, Jr., chair of the American Medical Association Reference Committee on Articles and Bylaws, is pictured above giving his report to the AMA House of Delegates at the Interim Meeting, December 7-11 in Atlanta, Georgia. Dr. Denser is a longtime member of the IMS delegation to the AMA and is also president-elect of the North Central Medical Conference.

Deceased members

Lawrence Cornish, MD, 67, family practice, Iowa City, died December 23

David Culp, MD, 76, life member, urology, Belleair Bluffs, Florida, died October 7

Dorothy Forsythe, MD, 78, family practice, Newton, died November 8

James Redmond, MD, 83, life member, family practice, Cedar Rapids, died November 11

Regis Weland, MD, 80, life member, pathology, Cedar Rapids, died October 4



Can you afford to ignore the Internet?

Probably not. Nearly 40 million people already have Internet access, and that number is expected to grow to 300 million people in the next three years. It truly is a new form of communication that's here to stay.

Besides, you're missing a wealth of information by not using the Internet. The Internet is a 24-hour virtual library of medical resources. The Internet also allows the exchange of e-mail and real-time discussion groups for doctors and patients.

With the Internet you can research the uses of a new prescription drug or communicate with colleagues around the world about new treatments.

Now is the time to jump on the Web

If you've been thinking about getting Internet access, now is the time. The Iowa Medical Society (IMS) has launched its web site, and it's something you don't want to miss.

The IMS web site makes it easy for Internet novices to find the information they need as they explore this new medium. Experienced users discover that the IMS web site will cut down their surfing time by making resources available at a click of the mouse. We're linking IMS physicians to the information they need!

Already on the Internet?

Jump to page 4 to find out how to get your password for the IMS web site.

What is the Internet?

The Internet is a giant network of interconnected computers. Through this global network, users can send e-mail, talk to other people in discussion groups and view web sites on the World Wide Web.

The World Wide Web is the part of the Internet that allows graphics, what you generally think of as the flashy part of the Internet. The other features of the Internet, such as e-mail, are text-based.

What do you need to get connected?

To get connected to the Internet you will need a computer, a modem, a telephone line and the software to link your computer to an Internet service provider. You will also need an account with a commercial online service or an Internet service provider.

Computer: Remember that your Internet software and your current software will run at the same speed. If your computer is sluggish now, it will be sluggish in cyberspace as well.

Most Internet service providers recommend that you have 16 MB of memory and at least a 486 processor for PCs. A system with a Pentium processor works best for the Internet. Macintosh computers work best running on System 7 or higher with 8 MB of memory and 3-5 MB of disk space for applications.

Modem: The faster your modem, the better it will be for using the Internet. Modems slower than 14.4 Kpbs will be frustrating to use. If you are buying a new modem, get a 28.8 Kpbs modem.

Telephone line: You might consider getting a separate telephone line for your modem, unless you don't mind having the line tied up while you are using the Internet.

Software: You will receive easy-to-install software from the commercial online service or Internet service provider when you set up an account. Make sure you also purchase a browser program, such as Netscape Navigator or Microsoft Internet Explorer. These programs allow you to view web sites on the World Wide Web. Many Internet service providers include these programs with their software.

How do you choose a service provider?

There are two primary ways to get connected to the Internet: through a national commercial online service such as CompuServe or AmericaOnline, or through a dedicated Internet service provider.

When deciding which route to take, consider that providers don't all charge in the same way. Find out the initial set-up fees and monthly charges.

Also ask about whether you can access the service by calling a local number. If you can't call a local number, you will pay long distance phone fees for the time you are connected to the Internet.

What is best for you depends on your use of the Internet. Commercial online services are easy for new users, but they limit the number of hours you can use the service each month. After reaching that limit, you pay for additional time. Internet service providers generally have more flexible plans based on the amount of time you expect to be using the Internet.

Internet service providers

Commercial online services

These national providers offer local access numbers for most Iowa communities.

CompuServe	800/336-6823
AmericaOnline	800/827-6364
Prodigy	800/776-3449

Iowa Internet service from local telephone companies

Iowa Network Services is a consortium of local telephone companies providing local Internet access in over 300 Iowa communities. Call your local telephone company for pricing and availability of Internet access. You can also call Iowa Network Services at 800/546-6587 for the participating company nearest you.

Other Iowa Internet service providers

Over 45 other Internet service providers operate in Iowa. You can find providers in your area by looking under "Internet services" in your phone directory or by calling Melanie Finke at the Iowa Medical Society at 800/747-3070. Physicians in the Des Moines area can purchase Internet service from Healthcare Solutions Group, the company that developed the IMS web site, by calling 800/391-3713.

IMS site links you to information you need

Why is now the perfect time to jump into the Internet world? Because the IMS web site will make it easy for you. The IMS web site gives physicians daily medical news, legislative updates and medical practice advice. The IMS web site also includes links to the best medical resources on the Internet.

- Find IMS position papers, updates on activity during the legislative session and links to legislators on the "Legislation and Public Policy" page.
- The 1995 E&M utilization data for Medicare is available on the "Medical Practice and Economics" page. You can also access the Practice Management Question of the Week and coding change updates.
- Register for upcoming practice management seminars and IMS conferences on the "Events and Seminars" page.
- Read up on the latest medical and legal news from the short media clips on the "Medical News" page.
- Communicate with IMS staff by e-mail on the "About IMS" page.

This is just the beginning. We will change and add to the IMS web site to meet physicians' needs. That means we want to hear what you think about the IMS web site. To give us your opinions, just click the "Feedback" button on our site.

How do you access the IMS site?

Simply type in http://www.IowaMedicalSociety.org. Some sections of the web site are for IMS members only, so you will need to call Laura Nelson or Melanie Finke at 800/747-3070 to receive your personal password. Typing in your name and password when you are prompted will allow you to view information on the "Legislation and Public Policy" and the "Medical Practice and Economics" pages. Your practice managers or administrators can access these sections also by using your name and password.

Call IMS at 800/747-3070 for your password today!

Friendship Providers, Inc.

Welcome to Managed Caring™, a whole new way of thinking about friendship. The Managed Caring™ Plan combines all the advantages of a "traditional" friendship network with important cost-saving features.

How does it work?

Under the Plan, you choose your friends from a network of pre-screened accredited Friendship Providers. All of your friendship needs are met by members of your Managed Caring™ panel.

What's wrong with my friends?

If you're like most people, you're probably receiving Friendship Services from a network of Providers haphazardly patched together based on where you've lived, worked, or gone to school. The result is costly duplication, inefficiency and conflict. Some Providers may not meet national standards, responding to your needs with inappropriate, outmoded, or experimental behavior. Under Managed Caring™, your friendship needs are coordinated by a designated Best Friend, who Cares™ about the quality of all your Friendships.

How do I know these aren't just a bunch of losers who can't make friends on their own?

Many of today's most dedicated and highly trained Friendship Providers are as concerned as we are about delivering quality Caring™ in a cost-effective way. They have joined our network because they want to focus on Caring™ for you rather than devoting their resources to the paperwork and high Bad Friendship premiums that have sent the cost of traditional Friendship Delivery systems skyrocketing. Our Friendship providers have met our rigorous standards of loyalty.



What if I need a special friend, say for poker or fishing?

Special Friends are responsible for most of the unnecessary Friendship Procedures that have sent the cost of the traditional Friendship Delivery system skyrocketing. By training, experience, and by virtue of knowing you for what you really are, your Best Friend is qualified to refer you to a Special Friend within the Managed Caring™ network should your needs fall outside the scope of his or her excellent training.

Suppose I want to see friends outside the Managed Caring™ network? Can my Best Friend ever refer me to them?

No. The only time you can see a Friendship Provider without first consulting your Best Friend is in the event of a Friendship Emergency.

What the hell is that?

The Managed Caring™ Plan covers your friendship needs 24 hours a day, 365 days a year anywhere in the world, even if you need a friend out of town, after business hours, or when your Best Friend is Caring™ for someone else. You may be on a business trip and find yourself lonely. In such a case, you may make a New Friend, and all appropriate Friendship Procedures delivered in this Emergency. Friendship will be covered under the plan, provided you notify us within two business days.

What Friendship Procedures are covered under the Plan?

Typical Friendship Procedures covered include (but are not limited to): chewing the fat, slinging the bull, shooting the breeze, hanging out, checking in, cheering up, kidding around, dropping over, partying, moaning, gossiping, joshing, ribbing, holding your hand, patting your back.

Are any Friendship Procedures not covered under the Plan?

Yes. Ineligible services include (but are not limited to): drinking in excess of six ounces of hard liquor or six servings of beer, lending sums in excess of $5, going the extra mile, exchanging ethnic or dirty jokes, and sex.

How can I find out if the Friendship Procedure I need is covered?

If you need a Friendship Procedure, call the toll-free number on your Managed Caring™ I.D. card to arrange for pre-certification of the proposed Procedure. All appropriate Procedures will be approved for coverage within 24 business hours.

But who decides what's appropriate for me?

We do. Isn't that what Friends are for? IM

The Managed Caring™ Plan covers your friendship needs 24 hours a day, 365 days a year anywhere in the world.

The evolving health care landscape . . .

Managing the transition

Discounting fee-for-service will not be sufficient to help your group compete with physician groups who are taking more innovative approaches. In this excerpt from a presentation in Iowa last fall, Dr. Jacque Sokolov talks about some of those approaches. Dr. Sokolov will speak at the 1997 IMS Scientific Session.



JACQUE SOKOLOV, MD
Dr. Sokolov is CEO of Advanced Health Plans in California. The company helps develop integrated health systems. About 40 medical groups and 15 Blue Cross Blue Shield plans are among his clients.

In 1990, there were 200 integrated delivery systems providing $100 million or more of aggregate physician-hospital services. By 2000, there will be over 1,200 integrated delivery systems all with aggregate physician-hospital revenues of $100 million or more. What we are seeing is the transition of a fragmented cottage industry into the corporatization of American medicine.

There is a tremendous amount of activity by physicians, hospitals and fiduciaries. In fact, some people say there is a great deal of heat but very little light.

Increasingly, large group practices are managing the risk for populations of patients. A large, multispecialty group gets organized, contracts with the hospitals and essentially goes into the marketplace saying it will accept the medical loss ratio.

There is a tremendous amount of activity by physicians, hospitals and fiduciaries. Some people say there is a great deal of heat but very little light.

Physician accept all risk

'Medical loss ratio' is an insurance term. Refering to the chart on the next page, for example, if a dollar comes into the health plan, 20¢ goes to administration and insurance and 80¢ goes to delivery of care. That 80¢ is translated into the medical loss ratio. As more physician groups — specifically, PHOs or variations on the theme — accept risk for the entire medical loss ratio, doctors and hospitals are increasingly preoccupied with managing this ratio, even to the exclusion of what one gets paid for under negotiated discounted fee-for-service contracts.

Mixed model is common

An integrated delivery system has at least one physician hospital linkage in the form of some type of physician organization, either a staff model where the physician works directly for the integrated delivery system or a group model where the physicians work for the group and the group is owned or contracted. The mixed model is most common — either primary care or multispecialty groups supported by an IPA or a network.

What is the difference between a very large, sophisticated integrated delivery system and the insurance company which bears risk for the entire population of patients? The insurance industry is concerned that there is very little difference between these levels of risk. As a result, across the country integrated delivery systems that are excepting large amounts of risk are getting insurance licenses.

This is a classic competitor/partner dilemma. If you are a delivery system that now becomes an insurance company you are competing with insurance companies and HMOs that historically were your partners. The opposite occurs when the insurance companies get into the delivery business, as Blue Cross Blue Shield and other for-profit companies have done.

Even in far away North Dakota . . .

One of our clients is Blue Cross Blue Shield of North Dakota. We were retained to look at how Blue Cross Blue Shield of North Dakota should work with their doctors and hospitals to integrate the entire state of North Dakota into some kind of delivery structure. Even in far away North Dakota, which seems less likely to make this transition than Iowa, there is activity going on where prepayment mechanisms will probably be in place within the next year.

What is really driving all this? Let's get back to the medical loss ratio. Twenty cents of every health care dollar goes to marketing and distribution; 80¢ to patient care delivery. As I said before, this is an 80% medical loss ratio.

Hospitals take 40¢ of this 80¢; doctors take 40¢ of this 80¢, and in Iowa, in largely discounted fee-for-service markets, the primary care revenue stream is about 10¢ and the specialty revenue stream is about 30¢. This is a one-to-three ratio of primary care revenue to specialty revenue.

In southern California, 75% of the population is in some kind of a risk plan. In that situation, the 80-cent medical loss radio is reduced by 25¢ — 15¢ is shaved off the hospital side and 10¢ off the physician side. The primary care to specialist ratio is one-to-one.

Where does it come from?

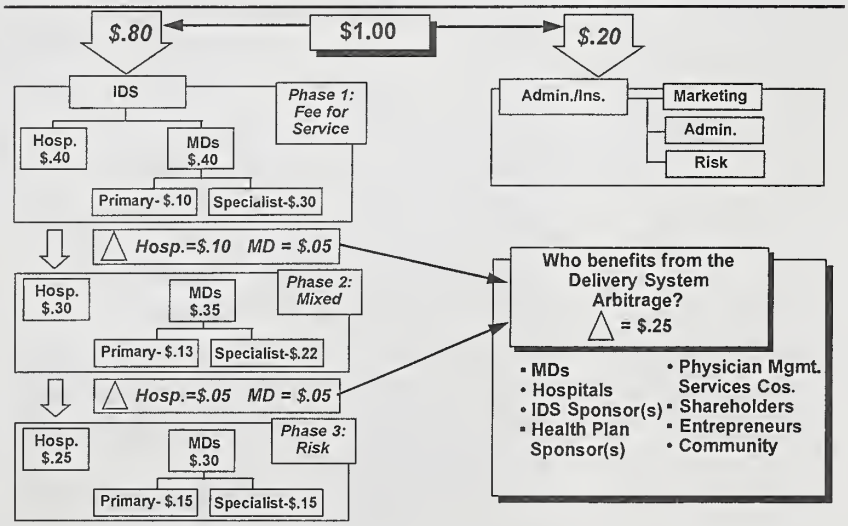
The 25-cent reduction is generated predominately by three interventions: 1) decreasing the length of stay, 2) decreasing the number and intensity of specialty referrals and 3) managing pharmaceutical benefits. Doctors, hospitals and others are significantly interested in capturing that 25¢ themselves and making it very clear to certain types of HMOs that the taking of that 25¢ is probably not going to be consistent with long-term relationships that are provider friendly.

This isn't discounted fee-for-service, nor is it simply reducing reimbursement to doctors and hospitals. This is clearly changing the type and practice of medical care across the country. So if you are in the situation, as North Dakota is, where you have Minnesota doing specific things which are reducing their medical loss ratio by 25¢ and you have to compete against them, and all you are doing is discounting your fee-for-service, you will never be able to discount fees enough.

Whoever is able to control the medical loss ratio calls the shots. It's that simple. If the physicians are not the drivers and, in some instances, are opposed to this concept, they

continued

Redistribution of Premium Dollar - The "Value Chain"



will eventually be outdone by an organization whose physicians understand how to manage their medical loss ratio. In certain parts of Iowa, you're going to be able to do the same thing if you get your act together to control the loss ratio.

As a result of getting into management of those 50 episodes of care, we saved about 25% of $175 million.

Gatekeeper or care manager?

This can be managed in either a centralized or decentralized approach. The two terms I use to differentiate this are gatekeeper versus care manager. I think you can do substantially more effective things not using gatekeepers. What's the difference between a gatekeeper and a care manager? Gatekeepers are given an incentive to restrict access to specialists and certain types of care.

A care manager approach is substantially different. When I went to work for Edison, I looked at the five most expensive populations of patients and at the 10 most expensive episodes of care. As a result of getting into the management of those 50 episodes of care, we saved about 25% of $175 million.

The way I managed them was a little different than you might suspect. I identified where the best care was being offered in an integrated way for these 50 episodes of care. We gave people incentives to go to these centers where there were patients on management teams and where Edison would provide a single point of contact and integrate the doctors, hospitals and insurance functions. When a patient was utilizing $100,000 plus of health care, there was somebody they could turn to who was their advocate in their course of treatment.

What will you be asked to deliver?

When you take on something as complex as an integrated delivery system, you need to know what your managed care vision is. Here in Iowa, you need to know how soon you will need a point of service plan, how you are going to deal with open-ended versus closed-ended HMOs, how soon are you will deal with a PPO transition, etc.

Somebody in your organization must understand what you're going to be asked to deliver in terms of managed care products. You can then identify how you are going to implement this from a governance/organizational standpoint.

At the very least, you need to know what percentage of your group revenue comes from fee-for-service and what percentage comes from prepayment in the three segments of Medicare, Medicaid and employer-based plans. In Iowa right now, there is probably very little from prepayment, so you take those numbers and project what you think is going to happen in 6 months, 12 months, 18 months, 24 months and 36 months.

Partnering continues to be an important issue. The most critical reasons to partner for long-term survival include: 1) capital, 2) managed care expertise, 3) maintaining your number of covered lives. If you are partnering for reasons that are not in those three categories, you are going to have substantial difficulties.

Quality, personal satisfaction

We must also maintain our concern over quality. I think the challenge for us is to strike a balance. Quality is very difficult to measure in a quantitative fashion but it still has to be there. There must be compassion — sometimes called customer service by more business-oriented approaches — producing some kind of a value-based product that make us competitive in the marketplace regardless of who is sponsoring the other products.

Obviously, most of us went into this profession to also meet the needs of our patients. You have to meet the needs of the people who are driving the purchasing decisions.

Finally, I think as providers of care, as physicians, we went into this profession because we saw personal and professional challenges that were satisfactory from both a career and a family standpoint. I think that when health care or the system of health care that you are associated with fails to meet your professional needs, neither will it meet your personal needs. IM

No front-load: misnomer or misleading?

PERSONAL FINANCIAL STRATEGIES

Whether it is a lump sum distribution for retirement, saving for college expenses or an inheritance, investors are faced with an onerous question: "What do I do with the money?"

Today, because of "new" investment alternatives, it is harder than ever to answer the question. Mutual funds are a convenient mechanism for investors to pool their resources and to diversify away some of the risk.

As you might expect, there are costs associated with every purchase. Fund costs are divided into two categories. Operating expenses are associated with every fund and are the costs of doing daily business. The second category of fund expense involves the costs paid to have a salesperson actually sell the fund. Commissions are taken directly out of the investment dollars deposited by the investor and are transferred to the salesperson. This is called a "sales load".

Over the course of many years, investment firms developed a system of investing that did not rely upon a salesperson. These funds paid no sales commissions and were called "no-load" funds.

There used to be only loaded funds and no-load funds. The choice was fairly simple. Today, however, the simplicity has been obscured. Because of high commission costs of traditional loaded funds and the enormous popularity of no-load funds, the brokerage industry was forced to compete. It responded by creating a new class of funds called "no front-load" funds.

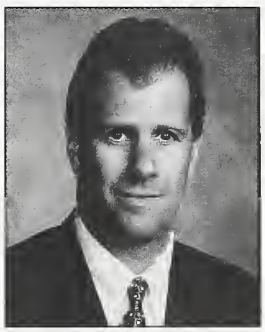
A no front-load fund is one in which a contingent or deferred sales charge might be deducted from the account at the time of withdrawal. Often, the deferred sales charge can be as much as 7% of the sum withdrawn during the first year and declining each year up to seven years.

You may think you avoid the commission if you leave your money invested until the deferred charge is gone. However, to pay the commission and cover the cost of the other fund's expenses, the no front-load companies charge an average of 2.75% every year! By comparison, the total ex-pense associated with the average no-load fund is only 1.07%. Indexed and asset class funds have costs in the range of .20%.

There used to be only loaded funds and no-load funds. The choice was fairly simple. Today, however, the simplicity has been obscured.

The brokerage industry is exceptionally good with metaphors. Contingent deferred sales charges and back end loads are metaphors for commissions. To make matters worse, they are buried deep within the arcane language of the prospectuses. With a true no-load fund, there is no sales expense charged against either the investor or the investment dollars.

The truth is patently simple; there are no-load funds and there are funds with loads. The rest is just bookkeeping. IM



JERRY FOSTER

Jerry Foster is the founder and president of Foster Capital Management, a fee-based financial advisory firm endorsed by the Iowa Medical Society. Mr. Foster can be reached at 1-800/798-1012.



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The Journal
of the Iowa Medical Society

Current therapy of Parkinson's disease

● *Todd Ajax, MD; Robert Rodnitzky, MD; Judith Dobson, RN*

Editor's Note: This is the second part of a two-part article. Part 1 was published in the January issue.

Fluctuations in medication response

In many patients who have had Parkinson's disease for several years, the duration of action of each dose of levodopa gradually becomes shorter. Most commonly this results in loss of the medication's effectiveness prior to the next dose, a phenomenon known as "wearing off". In more advanced stages, a smaller number of patients will experience abrupt loss of medication effect unrelated to the timing and dosage of levodopa. This is known as random "on-off". The treatment in both situations requires achieving as continuous a level of dopaminergic receptor stimulation as possible. However, the success in treating wearing off is greater than random on-off. Patients who experience a return or worsening of symptoms prior to the next dose will often respond to taking the carbidopa/levodopa in small but more frequent doses. Standard carbidopa/levodopa is seldom required at intervals less than every two hours or sustained release carbidopa/levodopa less than every three and one half hours. Increasing the dosing frequency further is usually not successful and other treatment stategies need to be pursued.

Selegiline, through its inhibition of the enzyme MAO-B, prolongs the efficacy of each dose of carbidopa/levodopa by slowing the catabolism of derived dopamine in the brain. This can be effective in treating wearing off. Side effects are mostly evident when this agent is combined with levodopa and include anxiety, confusion, hypotension or involuntary movements.

Sustained release carbidopa/levodopa has slower dissolution properties resulting in a slower fall in plasma levodopa levels between doses. It is therefore an effective strategy in treating wearing off. When making a change from the standard to the sustained release form, increasing the interdose interval by 50% is often possible.

Dopamine agonists are useful and often necessary adjunct therapy in patients receiving 600 to 800 mg of levodopa a day while still not being adequately treated or experiencing fluctuations in motor performance. Initial use of a dopamine agonist alone or combined with carbidopa/levodopa in newly diagnosed patients is advocated by some with the intention of forestalling response fluctuations attributed to chronic levodopa therapy. However, the lower clinical efficacy of these medications used alone and their higher side effect profile has tempered this approach. Both currently available dopamine agonists, pergolide and bromocriptine have a longer duration of action than levodopa and therefore are capable of providing more continuous dopaminergic receptor stimulation when used to supplement levodopa therapy.

Frequent side effects from this class of medications include nausea, hypotension, sedation and visual hallucinations. When the dosage of the dopamine agonist approaches a therapeutic level, the dosage of levodopa should be reduced 10 to 25%, if possible, to reduce the potential for side effects such as dyskinesias and hallucinations.

The role of diet

Dietary adjustments may be necessary in advanced PD since the rate of gastric emptying and the level of diet-derived amino acids may influence the absorbtion and central availability of levodopa. Gastric emptying is more rapid when the stomach is empty thereby allowing more efficient passage of levodopa to the small bowel where it is

The IMS Education Fund has designated this article as the Henry Albert Presentation Award for February 1997.

Todd Ajax, MD
Robert Rodnitzky, MD
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The authors are associated with the Department of Neurology at the University of Iowa College of Medicine, Iowa City, Iowa.

Current therapy of Parkinson's disease

continued

absorbed.

In advanced disease, a variety of dietary strategies are useful. Initially, the patient should be advised to take their dose of levodopa 20 to 30 minutes prior or one to two hours after each meal. This will improve gastric emptying of the tablet and reduce competition for active absorbtion. Instruct the patient to distribute their dietary protein evenly throughout the day and avoid meals with a high dietary protein content. If these measures are ineffective, introducing a low protein diet that eliminates almost all protein during the daytime and shifts a majority of the dietary protein to the evening meal may be necessary. These dietary manipulations require a great deal of compliance and are not practical in patients who have been poorly compliant in the past.

Dystonia

Dystonia may be a complication of PD itself, but more commonly results from chronic levodopa therapy. Dystonic dyskinesias usually develop during the decline in levodopa levels resulting in wearing off. This usually occurs at the end of an interdose interval. Strategies in medication adjustment include increasing the frequency of levodopa doses, switching to the sustained release preparation of carbidopa/levodopa, adding a dopamine agonist or introducing anticholinergic medication (benzotropine or trihexyphenidyl).

Early morning dystonia is a particularly common and bothersome complication resulting from falling plasma levodopa levels during the night. It usually involves the feet and can be extremely painful. The addition of sustained release carbidopa/levodopa or a dopamine agonist at bedtime may be helpful. Lioresal (baclofen) at bedtime is also a useful strategy for painful dystonia that develops during the night or early morning hours. Finally, awakening an hour before the painful dystonia usually develops and taking an additional one-half to one-whole tablet of standard carbidopa/levodopa is effective in preventing this symptom in some patients.

Freezing

Freezing is characterized by the sudden inability to initiate or continue a repetitive motor activity, most commonly walking. This may occur while walking when the patient encounters a real or imagined obstacle or when initiating gait. These episodes occur more often when the action of antiparkinsonian medications have worn off. Freezing may also occur during a period of maximum antiparkinsonian effect (i.e., during the "on" phase). For this circumstance, medication adjustments are not helpful. Rather, the patient may benefit from learning techniques to unfreeze such as walking to a cadence or rhythmn when approaching an enclosed place such as a bathroom or doorway. Stepping over an object like the handle of an inverted cane or lifting a foot high off the floor may be other useful techniques to initiate the first step.

Depression, psychosis

Behavioral symptoms may occur during the course of PD. Depression has been reported in approximately 50% of patients in some recent studies. Treatment with tricyclic antidepressants such as amitriptyline (Elavil) or nortriptyline (Pamelor) is often effective. The anticholinergic properties of these agents may exert a mild antiparkinsonian effect and improve sleep, however, they may aggrevate preexisting orthostatic hypotension or dementia and also must be used with caution, especially in the elderly or in patients with pre-existant dementia.

Psychosis is a possible complication in advanced, usually elderly, PD patients on multiple medications. Vivid dreams are sometimes a premonitory symptom of psychosis. They may progress to visual hallucinations, first in the evening and then during the daytime along with delusional and paranoid ideation. The first measure in addressing this problem is reducing the dose of medication; however, the symptoms of PD usually worsen.

Therefore, the least efficacious drug should be withdrawn first. Selegiline, amantadine, anticholinergics and dopamine agonists should be withdrawn in this order. A downward titration of dopamine agonists rather than complete withdrawal may be sufficient to treat persistent psychosis.

Other symptoms

Constipation is a very common problem in

PD secondary to autonomic dysfunction, medication effect, immobility and advanced age. Patients with severe constipation should maintain adequate hydration, avoid anticholinergic medication and incorporate extra fiber into the diet along with the addition of a stool softener. Cisapride (Propulsid) is a prokinetic drug that enhances intestinal motility and may improve constipation without exacerbating parkinsonism.

Excessive drooling, can be a major problem in some cases of advanced PD. The anticholinergic drug trihexyphenidyl (Artane) can be used to treat this symptom provided that contraindications such as dementia, constipation and urinary retention are not present. The peripherally acting anticholinergic agent propantheline (Pro-Banthine) is useful at doses of 15 to 30 mg three times daily. Its exclusive peripheral mode of action avoids exacerbating confusion or dementia.

Surgical therapies

Transplantation of fetal mesencephalic tissue has been performed at several centers. Although no controlled study of its effectiveness has been completed, uncontrolled studies and autopsy evidence suggest the transplanted tissue survives, parkinsonism is improved and patients' requirement for dopaminergic medication is reduced.

Lesioning the thalamus or implantation of a thalamic stimulator has been performed at several centers and is often beneficial for treating the tremor of PD when it is severe and refractory to medical measures. A thalamic stimulator has the advantage of avoiding a permanent lesion and can be applied to both sides of the brain with less risk to serious complications compared to bilateral lesioning. This therapy also allows the patient to control tremor severity by adjusting the amount of stimulation via a control device carried at his or her side.

Posteroventral pallidotomy is a procedure gaining widespread acceptance despite the lack of controlled studies documenting its effectiveness. This procedure has the potential of remarkably benefiting dyskinesias and tremor and to a certain extent to improve bradykinesia, rigidity, motor fluctuations and impaired postural reflexes. The benefit is primarily for symptoms contralateral to the side of the lesion; however, some improvement in symptoms ipsilateral to the lesion is sometimes seen as well. Potential risks include lesioning the adjacent optic tract, but this complication has been reduced through the use of intraoperative recording techniques and stimulation.

Bibliography

A bibliography may be obtained by contacting the authors or editors of *Iowa Medicine*. IM

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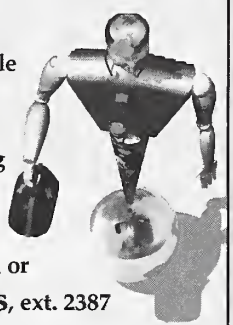
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IH&HS and IMS Regional Meetings March 6, 10 & 11, 1997

Compliance Programs: Good Preventative Medicine

The Attorney General believes that behind terrorism, health care fraud is the second biggest criminal problem in the United States. It is quite possible that your facility will receive a visit from a government agent. Imagine that agent asking your most disgruntled employee, "What has the facility done to comply with the law?" The answer may determine whether violations exist and whether you face exclusion from the Medicare or Medicaid programs, fines or even criminal penalties.

As a result, hospitals and physicians are being encouraged to adopt a compliance plan. The term is somewhat vague and confusing, leaving providers with many questions:

- Why isn't the old way of doing business good enough?
- What is a compliance plan?
- How do I implement one?
- Can I just buy a compliance plan from somebody?
- Will a compliance plan protect me from provider sanctions?
- What do I do when the compliance plan identifies a billing problem?

The Association of Iowa Hospitals and Health Systems and the Iowa Medical Society have asked two healthcare lawyers who have advised clinics and hospitals on compliance issues to help answer your questions. John Holdenried, Esq., of Baird, Holm, McEachen, Pedersen, Hamann & Strasheim in Omaha, and David Glaser, PA, of Fredrickson & Byron, of Minneapolis, will facilitate this educational seminar. During their presentation Mr. Holdenried and Mr. Glaser will provide pertinent information to help attendees better understand compliance programs and how they should be implemented. They will also provide a process to foster compliance with applicable laws and reduce potential penalties.

Who should attend this seminar? Hospital CEOs, CFOs, compliance officers, office managers, health information management staff, physicians, consultants, attorneys and persons responsible for assuring compliance by clinics and hospitals are encouraged to attend this program.

Date	Location	Room	Time
March 6	Mercy Medical Center, 701 10th Street, Cedar Rapids	Marron Room	9:00-11:00 a.m.
March 10	Iowa Methodist Medical Center, 1200 Pleasant Street, Des Moines	Hill Auditorium	9:00-11:00 a.m.
	Ottumwa Regional Health Center, 1001 Pennsylvania Avenue, Ottumwa	Conference Rooms B/C	1:30-3:30 p.m.
March 11	Marian Health Center, 801 Fifth Street, Sioux City	Classroom E	8:30-10:30 a.m.
	Jennie Edmundson Memorial Hospital, 933 East Pierce Street, Council Bluffs	2HA Classroom	1:30-3:30 p.m.

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Return to: Linda Parker, Program Registrar
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Dreams: a reflection of who we are

To "dream" has two connotations: a series of thoughts, images or emotions occurring during sleep; or a goal or purpose ardently desired. Goethe declared, "Our dreams are presentments of the faculties latent within us, and signs of what we may be capable of doing. What we can do and what we wish to do loom in our minds as something belonging to the future and outside us; we crave for what we already possess."

Dreams in themselves are the purist form of enchantment. In a dream we may find ourselves captured by personalities, locales, events, moods, magical events and terrors. Upon awakening we become aware of that enchantment as we reenter the world of daily living. A dream of hopes and aspirations may linger in our minds to be later cast aside as impossible, improbable or substituted by other dreams. Some dreams may not be understood or seem unimportant.

Thomas Moore stated in his book, *The Re-enchantment of Everyday Life*, that the "most valuable gift of dreams is not specific insights or meanings—most of us have too many ideas about ourselves—but rather a development of an attitude toward life that appreciates the importance of imagery, mystery and interior experience." Dreams can teach us how to live, how to appreciate our own thoughts, the beauty of the world around us and how to see our soul in our work. Nothing in our life is simple, nothing is without its poetry and nothing that truly affects us is void of an inner dream core.

What of your dreams? Undoubtedly we physicians ardently desired to attain our goals and dreamed often of becoming a physician. Those dreams may have been stimulated by a family member or an esteemed professional acquaintance. Those dreams were hopeful goals, not images in our sleep. In active practice I seldom had dreams of the trials of a complicated case or diagnostic problem, Yes, I often did ponder before falling asleep over a medical problem or a severely ill child.

However, since retiring I have had recurrent dreams of experiences in medical school, during internship and residency, and more lately, after nearly nine years of retirement, of practicing pediatrics. Well-baby examinations and instructing parents in child care (but not often of severely ill children or diagnostic dilemmas) have been in my dreams.

Since retiring I have had recurrent dreams of medical school, internship, residency and practicing pediatrics.

Some of my retired colleagues have related similar experiences in their dreams. How about others in our ranks? Have you had similar experiences? Let's not try to analyze our dreams, for after all, dreams fit into the context of our lives; more a reflection of who we are, and that isn't so bad, is it? IM



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Long-distance education

Perhaps many physicians envision long-distance education to occur at sites remote from the communities in which they practice. In this scenario the physician is the literal traveler, joining colleagues at a conference to which experts have been invited to share advances in medical practice.

The advent of new technology compels us to redefine this concept. The ability to transmit "real time" audio and visual information among dispersed geographical locations obviates the need that the educator and learner be in the same place. Indeed the large number of formats made possible by the technology begs the question: just who is the educator?

There has been enough experience with the transmission of programs from one site to another (via satellites or more recently fiberoptic cable) to reach one conclusion about formats: physicians are not enthusiastic about "talking head" long-distance education. Deprived of the immediacy of contact with the presenter, coping with visual aids that may not be well-suited for the medium, and enduring a lengthy lecture on a monitor discourages the learner. The mechanics of asking questions can also be inhibiting, making the participant fell self-conscious.

It is certainly possible to gather an audience for a stellar presentor, but many organizers of series of long-distance learning activities using this format express disappointment about participant attrition, either during a single event or over time.

What is to be done? One approach is to structure long-distance programs so that all participants are educators and learners. This notion is not simply a fond ambition, but is the direct consequence of assuring interaction during the learning event.

Interactive learning promotes sharing of information and ideas, critical thinking about issues and mutual respect among participants.

A number of formats facilitate interaction, including the use of concise (10-15 minute) presentation modules, followed by discussion; case studies developed by the "learner"; and informal assessment during the session with discussion of the posed questions.

Interactive learning promotes sharing of information and ideas, critical thinking about issues and mutual respect among participants.

Medical education program planners wanting to use long-distance technology should first focus on what formats best suit the issues to be developed in the program. Assuring that the electronics are in order is only one element; being certain that ideas will flow is the essence of the medium. IM



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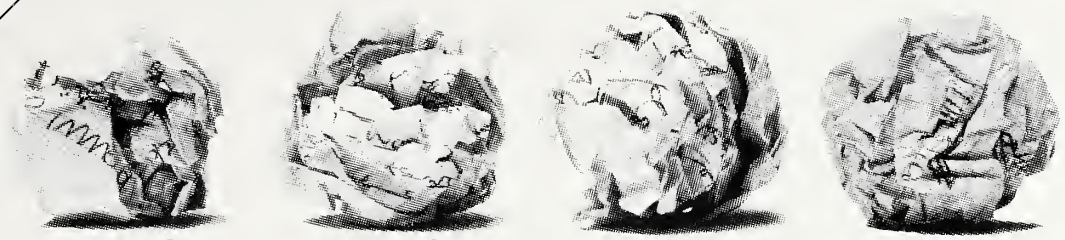
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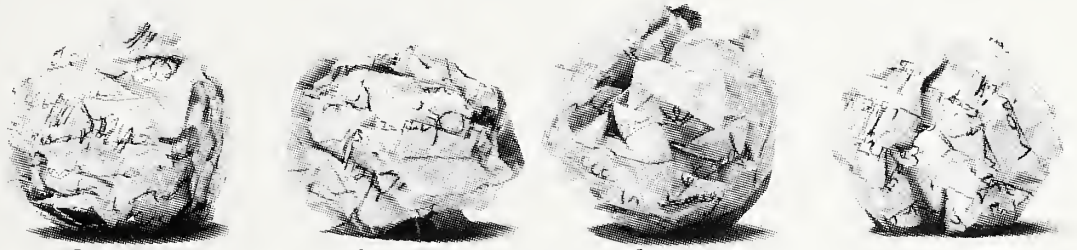
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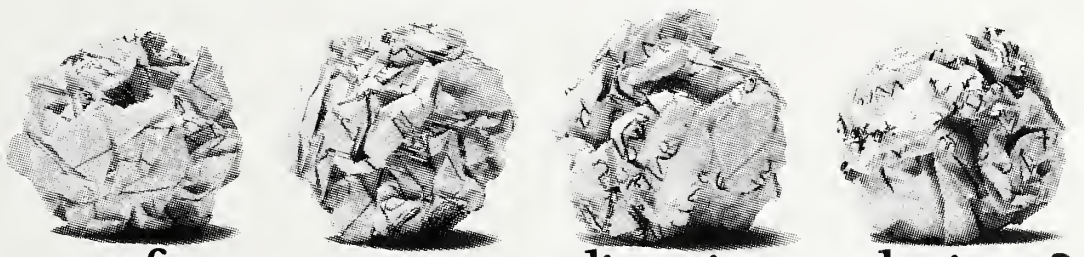
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Iowa Medicine

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It is easier to build strong children than to mend broken men. **Frederick Douglass**

Socioeconomic impact of child abuse

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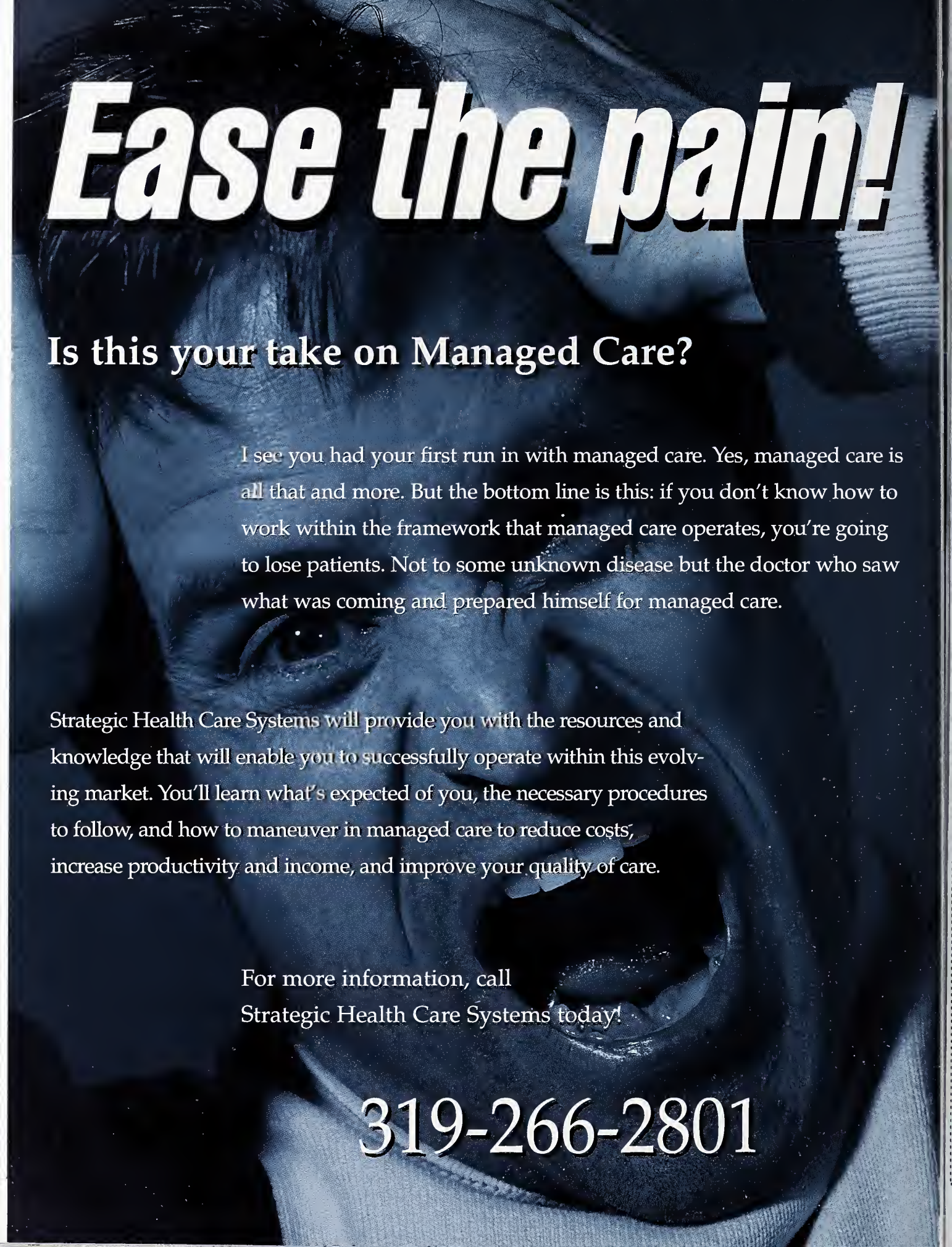
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Child abuse and the physician

Learn the six legally defined types of child abuse, reporting and training responsibilities of Iowa physicians

page 117

Plus tips to ensure your expert witness testimony is effective in court!


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IMS *DEADLINE* news

March, 1997

Late-breaking news of interest to Iowa physicians

●**AS OF PRESS TIME, AN IMS-SPONSORED POINT-OF-SERVICE BILL** had passed the Iowa House and was set to be considered by the Senate. The bill would require health plans which restrict the choice of physicians or hospitals to offer an optional point-of-service feature so patients may self-refer to physicians outside the plan at additional cost to themselves.

●**ALSO IN THE MANAGED CARE ARENA,** IMS staff are assisting an Iowa physician who was "deselected" by a payer who signed the Principles of Agreement Under Managed Care. The Principles were created by the IMS, the Iowa Academy of Family Physicians and other organizations representing health care providers, working with representatives of major payers. The organizations recently signed off on an updated version of the Principles. The Iowa physician in question was deselected without being allowed a meeting with the payer to discuss the problem. This is a violation of the Principles. The IMS is working with the company to remedy the situation.

●**THERE IS STILL TIME TO PLAN TO ATTEND** a joint IMS – IH&HS program on "Compliance Programs: Good Preventive Medicine". Because the government believes health care fraud is a huge problem in the United States, it is imperative for physician offices to be prepared for a possible visit from a government agent. One sure way to protect yourself is through a compliance program. This program, sponsored by the Iowa Medical Society and the Association of Iowa Hospitals and Health Systems, will show you how to implement a compliance plan. Two health care lawyers who have advised countless clinics and hospitals on compliance issues will be available to answer your questions. The program dates are: March 6 at Mercy Medical Center in Cedar Rapids; March 10 at Iowa Methodist Medical Center in Des Moines; March 10 at Ottumwa Regional Health Center in Ottumwa; and March 11 at Marian Health Center in Sioux City. Anyone responsible for insuring billing compliance is encouraged to attend. For more information, call Linda Parker at IH & HS, 515/288-1955.

●**CONSULTEC HAS BEEN SELECTED AS THE NEW IOWA MEDICAID** fiscal agent, and Consultec is looking for a full time MD or DO to perform a variety of medical review functions. Requirements include a current license and practice experience during the past two years. A physician board certified in general practice, family practice or internal medicine is preferred. Send resumes to: Consultec, Edgewater Building, 4200 University Avenue, Suite 304, West Des Moines, Iowa 50266.

●**THE IOWA DEPARTMENT OF PUBLIC HEALTH** is applying for a grant from the Robert Wood Johnson and W.K Kellog Foundations to strengthen Iowa's public health system. In addition to the statewide grant, local organizations may apply for grants of up to $60,000 for a three-year period to address community health needs. Letters of intent are due no later than March 10. Proposals of no more than two pages are due by mail on Friday, March 21. For more information, call Carl Kulczyk, program planner at the Iowa Department of Public Health, 515/281-7223.

●**THE IMS AND MIDWEST MEDICAL INSURANCE COMPANY,** the IMS-affiliated liability insurer, are working together to establish the Physician Litigation Support Program and are looking for volunteer physicians who will offer assistance, information and emotional support to colleagues who are being sued. For more information, call Lori Atkinson at 800/798-9870.

For more information about any *DEADLINE* news item, call Chris McMahon at IMS headquarters, 515/223-1401 or 800/747-3070.

Iowa Medicine

JOURNAL OF THE IOWA MEDICAL SOCIETY MARCH 1997 / VOLUME 87 / 3



No one deserves to be hurt.

About the Cover

This special issue is the kick-off for the IMS campaign on child abuse. Photos were used with permission from the American Academy of Pediatrics and the C. Henry Kempe National Center. IMS member physicians who want a poster reproduction of the cover should call Bev Corron at the IMS, 515/223-1401 or 800/747-3070.

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When we don't raise healthy children, we pay the price one way or another.
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I mean really, it's for our kids

If children truly are the future, let's look at how well we're preparing for that future. As a nation we have spent ourselves into a mind-boggling national debt that our children will have to repay. Is it a safer world for them? We outspent and then outlived communism but now we have AIDS, homicides, suicides, abortions, drugs and abuse.

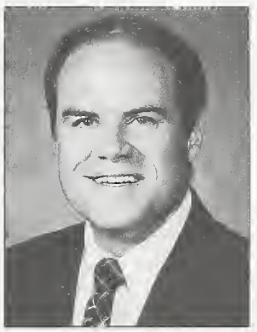
So how well are we preparing our children for being parents? For doing a better job than we did? Our national divorce rate is at least 50% and our teenage pregnancy rate is the highest in the industrialized world. Of course it could be worse. Of the more than one million U.S. teenagers who became pregnant last year, more than half of the pregnancies end in abortions. Still the 50% of these infants that survive pregnancy have a father to help them, right? Actually, no.

Of the 4,041 live births to Iowa teens in 1994, 3,217 or 80% were born out-of-wedlock and national statistics say two-thirds of the children in father-absent homes receive no child support. At least they are healthy babies. Well, not really. Because of a lack of maturation, teen females have a high incidence of low birth weight babies who cost 10 times as much to deliver.

Of the 4,041 live births to Iowa teens in 1994, 3,217 or 80% were born out-of-wedlock.

This national disgrace strains the fabric of our society and combined with child homicide, suicide, AIDS, drugs and child abuse threaten to destroy the future for our children. I guess a society that sets a value of $55 million for a baseball player or $35 million for one act of violence needs to get its nose out of the stock market and out of politics and onto the streets of our towns where a struggle with poverty and disease is being lost.

As part of our ongoing public health initiative the Iowa Medical Society (with strong IMS Alliance leadership) is trying to arrange for a "Baby Think It Over" doll experience for every teen capable of childbirth. No public health initiative in my town has gained more interest or more support. From the County Medical Society to the Rotary all are anxious to buy at least one baby for this effort. Let's not stop there. The evolving relationship between medicine and public health will address our most basic health problems. In fact, the future economic and professional viability of hospitals and practices rests on how well we collaborate to deal with key issues for the health of individuals, populations, health professionals and health institutions.



William McMillan, MD
IMS President

Again, there is no greater reward than the ongoing success and happiness of our families. Let's make the solution personal and the process professional and the results will be public with personal pride, professional success and community health for all. I mean really, it's for our kids. IM

A journey into cyberspace

1997 IMS Scientific Session

Iowa Medical Society

Scientific Session Friday, April 18
House of Delegates Saturday, Sunday, April 19 & 20



Join us at the Des Moines Embassy Suites Hotel on Friday, April 18 for a Journey into Cyberspace and the exciting new world of telemedicine, virtual hospital, electronic medical records and much more. And, it's all free for Iowa Medical Society members!

Then, plan to take part in IMS policy-making and elections on Saturday and Sunday, April 19 and 20, at the IMS House of Delegates Annual Meeting. Special weekend guest will be Dr. Nancy Dickey, AMA Board of Trustees chair.

Managed care, too!

On Friday afternoon, nationally-known expert Jacque Sokolov, MD will discuss advanced health plans, performance-based networks and optimal physician organizations. (Dr. Sokolov got rave reviews at a recent meeting of Iowa clinic managers.) You won't want to miss this presentation.

BRING YOUR FAMILY!

There's plenty for your family to do in Des Moines while you participate in the IMS meetings. Transportation will be available to the Blank Park Children's Zoo, the Science Center, Living History Farms, shopping malls and a number of other Des Moines attractions. Babysitting services will also be available for guests.

Friday, April 18

9:00 A.M.–9:50 A.M. — Scientific Session registration

10:00 A.M.–5:00 P.M. — IMS Scientific Session (CME credit made possible by the University of Iowa)

6:00 P.M.–9:00 P.M. —IMPAC Open House

Saturday, April 19

7:30 A.M. — Continental Breakfast hosted by Blue Cross Blue Shield of Iowa

8:30 A.M. — IMS House of Delegates

1 P.M. — Reference Committee hearings

3:00 P.M. — Risk Management Seminar

6:00 P.M. — President's Reception

7:00 P.M. — Annual Banquet

Sunday, April 20

8:00 A.M. — Continental Breakfast hosted by Blue Cross Blue Shield of Iowa

9:00 A.M. — IMS House of Delegates, officer elections

To register for the Friday Scientific Session and the Saturday Annual Banquet and/or to reserve hotel rooms at the Embassy Suites Hotel, call Becky Bales or Cheri Jensen at IMS, 800/747-3070 or send an e-mail message to imsadm@netins.net.

New on the Net

Patient information from Iowa hospitals

Useful patient information is the key to some of Iowa hospitals' web sites, providing physicians with good Internet sources for patient education.

Both Iowa Health System and Des Moines' Mercy Hospital Medical Center have quick fact sheets and articles you can download from their sites. Among the topics IHS offers are prescription refills, heartburn and ear infections. *http://www.ihsdesmoines.org*

Mercy lists pages of resources from bug bites to ergonomics to healthy diets to cancer. *http://www.mercydesmoines.org*

For more general health articles, check out *An Apple a Day,* a health e-zine from St. Luke's Health System in Sioux City. Its January-February issue features an impressive article on how to judge the credibility of Internet health sites, as well as diet and fitness tips. *http://www.siouxlan.com/stlukes*

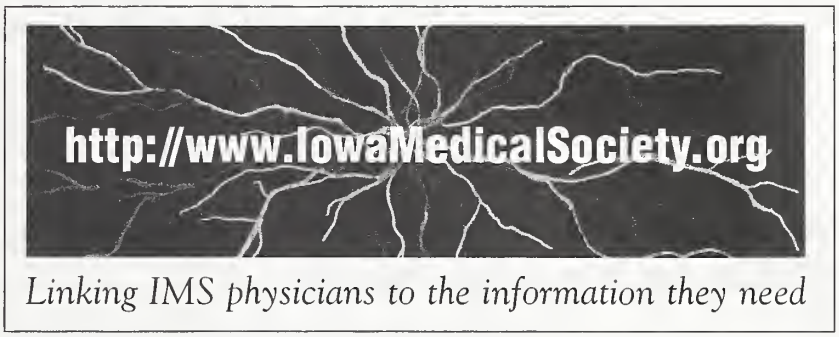
Point patients who are interested in learning more about managed care to Cedar Rapids' Mercy Medical Center for a well-written article: "What Exactly Is Managed Care?" *http://www.mercycare.org*

See IMS Internet Hints on the IMS web site for more ideas and links for using Iowa hospitals' web sites for patient information.

Learn from UI Virtual Hospital experts

The University of Iowa's Virtual Hospital is also a must-see source for patient and physician information. Among its vast resources are the Hardin Library, the Family Practice Handbook and the Iowa Health Book. *http://vh.radiology.uiowa.edu*

Members from the UI Virtual Hospital staff will be providing hands-on Internet training at the IMS Scientific Session and throughout the weekend April 18-19. Plan to tag-along for "A Journey into Cyberspace" and the world of medicine on the Internet.



Linking IMS physicians to the information they need

Hot sites

Thriving resource: Get fact sheets about conditions, drugs, surgical procedures as well as article summaries and lists of support groups from "thrive@health". The site, recommended by staff of the University of Iowa's Virtual Hospital, requires you only to type in a topic and wait for the resources to come to your computer. *http://pathfinder.com/thrive*

Taxing site: The Internal Revenue Service has created a site to help the nation's citizens conquer the upcoming tax season. Be prepared to take some time on this site, because graphics are extensive and advice for businesses interesting. You can also download forms and publications from the site. *http://www.irs.ustreas.gov*

Political junkies: "Politics Now" connects you to complete coverage of politics, elections and the government. Besides the latest news from national media, you can find out how your congressman is representing you. *http://www.politicsnow.com*

Shareware heaven: Bored with your Windows 95 screensaver? Check out Galt Technology's Shareware Zone, a site full of screensavers, utilities and games you can download for Windows and Windows 95. Galt's Screen Saver Heaven features over 500 screensavers. *http://www.galttech.com* IM

IMS staff members are on the watch for sites that might interest Iowa physicians. Staff members visit all Hot sites *to make sure they have useful information and reasonable download times. Suggestions for* Hot sites *can be sent to Melanie Finke by e-mail at communic@netins.net or by telephone at 800/747-3070.*

MANAGED CARE

news you can use

Dubuque hospital scraps merger plans

According to a story in the *Des Moines Register*, Dubuque's Finley Hospital and Mercy Health Center have called off efforts to form a partnership after nearly four years of working on the proposed merger. A spokesperson for Finley Hospital said delays resulting from a U.S. Department of Justice lawsuit sparked the decision. In a written statement, Finley's president said the hospital merger "made sense four years ago" but that the marketplace has changed.

Three-day stay for heart bypass, says HMO

Following guidelines developed by Milliman and Robertson, an Illinois-based HMO has told its physicians that the goal length of stay for heart bypass surgery is three days. Although the HMO states that the guidelines are goals and not something that must be adhered to, many cardiologists fear that HMOs will put considerable pressure on physicians to comply with this recommendation.

Majority of people have no understanding of managed care

A Louis Harris survey of 1,081 people found that 55% had never heard the term "managed care" and had no understanding of its meaning. Thirty-one percent didn't know what an HMO was; 25% of those who participated in an HMO or PPO did not realize their choice of physicians was limited. This widespread ignorance is attributed to poor efforts by HMOs to clearly define how they operate and how they select physicians.

The University of Iowa buys its first physician practice

The University of Iowa — through a for-profit subsidiary called University of Iowa Community Medical Services, Inc. — has purchased the Heartland Family Health Associates, a group of three family practice physicians and a physician's assistant in Perry. Within three years, the Perry practice could expand to over 50 primary care physicians at 15-20 sites around Iowa, said a U of I spokesperson. According to an article in the *Des Moines Register*, the U of I is interested only in primary care practices (family practice, internal medicine and pediatrics). In the same *Register* story, several physicians representing large physician groups expressed concern over a public institution such as the U of I competing in the private sector.

Providers say rules for risk-bearing provider networks inflexible

The Minnesota health and commerce departments have unveiled two proposals for risk-bearing provider networks, neither of which are drawing praise from the provider community. Under both plans, the state could audit the networks at any time. Providers are disappointed that the regulations include high capitalization requirements and are inflexible.

Primary care access paramount for Mercy Services

(Eighth in a series)

Mercy Services Iowa City was established in 1984 to provide primary care services to patients in the southeast section of Iowa, especially those in rural areas. As the number of family practitioners in the outlying communities decreased through retirement and death, Mercy felt it had a responsibility to the communities it served to ensure their access to primary care was maintained.

Primary care network

Bill Watts, vice president and director of outreach services for the nine-clinic organization, cites a secondary reason for establishing Mercy Services Iowa City: "As changes in regulations, economic conditions and social responsibilities increased, hospitals all over the nation were seeking ways to strengthen themselves. The Mercy organization in Iowa City, as well as many other health care organizations saw benefits in developing primary care networks."

One way these networks were developed was by purchasing physician practices. In 1987, Mercy Services Iowa City acquired its first medical practice. During the next year, the primary care network expanded to five communities and by 1995 four additional communities came under the Mercy Services Iowa City umbrella. Today there are 22 primary care physicians, two physician assistants and one family nurse practitioner.

Practice medicine; leave the business to us

Many physicians want to practice medicine in smaller Iowa communities for various reasons. However, not all of them have the business expertise, management training or capital. These concerns as well as other issues such as regulations, reimbursement, billing and recruitment take time away from actual patient care. Under the Mercy Services system, the business side of medicine is handled by professionals who excel in that area.

Mercy Services also offers recruitment, practice management support and computerization assistance to other providers in the area. "Providing this support helps to maintain access to health care in these communities, provide patients with the best possible primary and advanced health care and strengthen the entire health care system," Mr. Watts explains.

Collaboration over competition

Although Mercy Services Iowa City competes for primary care physicians and patients in Iowa City and Cedar Rapids, Mr. Watts points to the ways Mercy Services works with area physicians and providers. One such example is Cancer Care of Iowa City. Mercy Services and the University of Iowa Hospitals and Clinics collaborated to create this clinic which is staffed by physicians from both groups.

Mercy's vision for the future

The goal for Mercy's future is clear: "By the year 2000, Mercy will be the most convenient high-value provider of personalized health care and community health services for southeast Iowans." Its objectives are to improve clinical outcomes, access and community health status and reduce expenses.

For physicians deciding where and how to practice medicine in the future, Mr. Watts has this advice to offer: "Once you identify the general location, the style of practice (hospital, clinic) and the type of services you want to offer, shop around and visit with physicians and staff at each site. It's difficult for patients when physicians leave their practice, so make your decision carefully." IM

"Shop around and visit with physicians and staff at each site."

KEY CONTACTS:

Mercy Services Iowa City, Inc.
319/339-3541

Ronald Reed
President and CEO

Bill Watts
Vice president and director of outreach services

If you know of other innovative practice arrangements we should write about in Iowa Medicine *— especially those controlled by physicians and positioned to compete in the managed care market — call Barb Cannon or Chris McMahon at the IMS, 515/223-1401 or 800/747-3070.*

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IMS Update

Good response to IMS survey

Nearly 1,100 Iowa physicians answered a survey conducted by the Iowa Medical Society. The survey was mailed in January to all practicing physicians in Iowa and garnered a 20% response.

The survey is the first component of a comprehensive strategic planning process being undertaken by IMS this year.

Based on the survey results, focus groups, leadership retreats and telephone interviews with physicians who are not IMS members, a 12-member task force will determine the future direction of the IMS. Every phase of IMS operations is being examined to ensure that members are being offered the services they want.

The Board of Trustees was scheduled to hear a report on the survey results at its February meeting. Watch future issues of *Iowa Medicine* for information on the results.

Thank you to all the physicians who took time to complete the survey.

News at a glance

The 1997 Iowa Family Practice Opportunities Fair will be August 23, 1997 at the Savery Hotel and Des Moines Convention Center. It will be sponsored by the Iowa Family Practice Residents Council, the UI College of Medicine, the Iowa Medical Society and the Iowa Academy of Family Physicians. For more information, call 319/335-8618.

AMA Board Chair Nancy Dickey was present at the U.S. Supreme Court when the Justices heard oral arguments on the issue of physician-assisted suicide. Immediately following the arguments — which were closed to the press — Dr. Dickey was interviewed on the steps of the Supreme Court building.

Top AMA officer at IMS Annual Meeting

Dr. Nancy Dickey, chair of the AMA Board of Trustees, will be a special guest at the Iowa Medical Society's House of Delegates Saturday and Sunday, April 19-20 at the Embassy Suites, Des Moines.

Dr. Dickey will participate in the weekend's activities and will address the House of Delegates Saturday morning.

continued

News from Iowa Medical Group Management Association (IMGMA)

Eye-opening MGMA survey report

Corporate downsizing is a term with which we are all familiar. Mergers and acquisitions in the corporate world are synonymous with reduced staffing. One would think it would lead to greater profits. This is not true according to a recent study conducted by the Medical Group Management Association. It found that reducing staff may severely impact a practice's long-term profitability and performance.

The report shows the average practice can become more efficient and profitable by increasing its support staff. The best performing multispecialty practices in the country have more support staff per physician than the average practice. The average for all multispecialty groups was 4.63 full-time equivalent per physician, but the best performing practices average 5.37 full-time support staff per physician. The top practices appear to be better at leveraging their mid-level providers.

The top practices also employed more LPNs and medical assistant but fewer RNs. In spite of spending more on support staff, their revenues per physician were about $67,000 higher than the average practice. In terms of support staff costs as a percentage of net medical revenues, the average practice ratio was 24.39%. Because of their higher revenues, the top practices spent only 21.32% on support staff.

The findings of this MGMA study demonstrate that professionally managed practices are more profitable in the end. It is important for physicians to work closely with their clinic managers and administrators to achieve their mutual goals.

IMS Update
continued



Dr. Nancy Dickey

Dr. Dickey, a family physician from College Station, Texas, has held a number of offices in the AMA. She was elected chair of the AMA Board of Trustees in November of 1995. She has acted as spokesperson for the AMA on a number of important issues, most notably, physician-assisted suicide.

Scientific Session Friday, April 18

Watch the mail for your 1997 IMS Scientific Session program and registration form. The Scientific Session — ***Journey into Cyberspace*** — will be held at the Des Moines Embassy Suites on Friday, April 18 in conjunction with the IMS House of Delegates.

You will receive your program in early March. To register, return the form included with the program or call Becky Bales at the IMS, 515/223-1401 or 800/747-3070. IM

Focus on IMS Alliance

Congratulations to volunteer physicians

The IMSA has awarded Presidential Citations to individuals who enhance the health and safety of others by: (1) educating the public by sharing a personal health/medical challenge; (2) inspiring and motivating others by the way a health/medical adversity was handled; (3) volunteering a skill or knowledge; (4) engineering an ingenious idea.

Congratulations to all Iowa physicians receiving the Presidential Citations:

- **Dr. James Blessman**, Des Moines, for establishing free medical clinics across Iowa;
- **Dr. Robert Lee**, Des Moines, for publicizing the need for physicians to provide education and encouragement for smokers to become non-smokers;
- **Dr. Tom Smith**, Ames and **Dr. Jeffrey Carithers**, Des Moines, for providing facial plastic and reconstructive surgery to domestic abuse survivors;
- **Dr. James Reed**, Ft. Dodge, in celebration of his 4,000th delivery;
- **Dr. Gary Peasley**, Marshalltown, for educating the public about the dangers of tanning;
- **Dr. Arthur and Ruth Guyton**, for encouraging all 10 of their children to become physicians;
- **Dr. Alexander Matthews**, Des Moines for sharing his bypass surgery and angioplasty techniques with Russian physicians;
- **Dr. Greg Ganske**, Des Moines and Washington, DC, for performing charity medical work in Peru.

Specialty Society Update

The Iowa Medical Group Management Association has named its 1997 officers: Denise Chaffee, president; Nephtali Matta, treasurer; Julie Barto, secretary; Nancy Park, past president; Julie Drews, Sue Hopkins, Robert Mason, Jeanette Sargent, Terry Stone and Sue Marsh, board members. The board established a procedure for electing a new president-elect for 1997. A $1,000 scholarship is available to attend the MGMA Midwest Section Meeting. Call the IMGMA office for more information.

The American Medical Directors Association, Iowa Chapter elected officers at its Annual Meeting: Clifford Rask, MD, president; Keith Garber, MD, vice president; Roberta Wattleworth, DO, secretary-treasurer; Ron Roth, MD, Gerald Jogerst, MD and Paul Ferguson, MD, board members.

The top legislative priority this year for the Iowa Psychiatric Society is the required licensing of physicians who conduct utilization review. Essentially this means defining the practice of medicine to include utilization review. The goal is to hold accountable physicians who conduct reviews, especially those in managed care settings.

For more information, contact Dana Petrowsky or Dave Furneaux at 515/223-2816 or 800/728-5398.

Family Practitioners

Gundersen Clinic, Ltd., is seeking two BC/BE Family Practitioners to join our practice in the picturesque hills of northeast Iowa. West Union is part of Gundersen's regional rural network, a system staffed primarily with Family Physicians. The regional network is supported by both on-site and immediate phone consultative services (Medlink) from the 300-plus multi-specialty physician group in La Crosse, Wisconsin.

The West Union practice includes six community clinics, with the hospital and main practice located in West Union. The practice currently includes five Physicians (including a General Surgeon) and four Physician Assistants. Obstetric practice is highly desirable. Call is 1:4. Gundersen Clinic offers competitive salaries and excellent fringe benefits.

If you are looking for a practice that has all the positives of rural life, coupled with the strengths and support of a large multi-specialty teaching institution, please send letter of application and Curriculum Vitae to Frank Perez-Guerra, Manager, Recruitment, Retention and Resource Planning, Gundersen Clinic, Ltd., 1836 South Avenue, La Crosse, Wisconsin 54601; or call 1-800-362-9567, extension 6325.

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"ETHICAL ISSUES IN MEDICINE: CRITICAL PERSPECTIVES"
Wednesday, April 23, 1997

Guest Faculty	Topics
Thomas Szasz, M.D. Professor of Psychiatry Emeritus State University of New York Health Science Center Syracuse, New York	**"Suicide: Physician-Assisted and Unassisted"**
Bruce D. White, D.O., J.D. Clinical Director Clinical Ethics Center St. Thomas Hospital Nashville, Tennessee	**"Integrating Ethics Into the Fabric of the Health Care Environment"**
A. Albert Howsepian, M.D., M.A.(abd). Department of Philosophy University of Notre Dame Notre Dame, Indiana	**"The Ethical Significance of Advance Directives"**
Francis J. Beckwith, Ph.D. Assistant Professor of Philosophy Whittier College Whittier, California	**"Are HMOs Unethical?"**
The Reverend Allyne L. Smith, Jr., Ph.D. Visiting Scholar Department of Theology University of Notre Dame Notre Dame, Indiana	**"Futility"**

Mercy Hospital Medical Center designates this CME offering for 4 hours in Category I of the AMA Physician's Recognition Award.

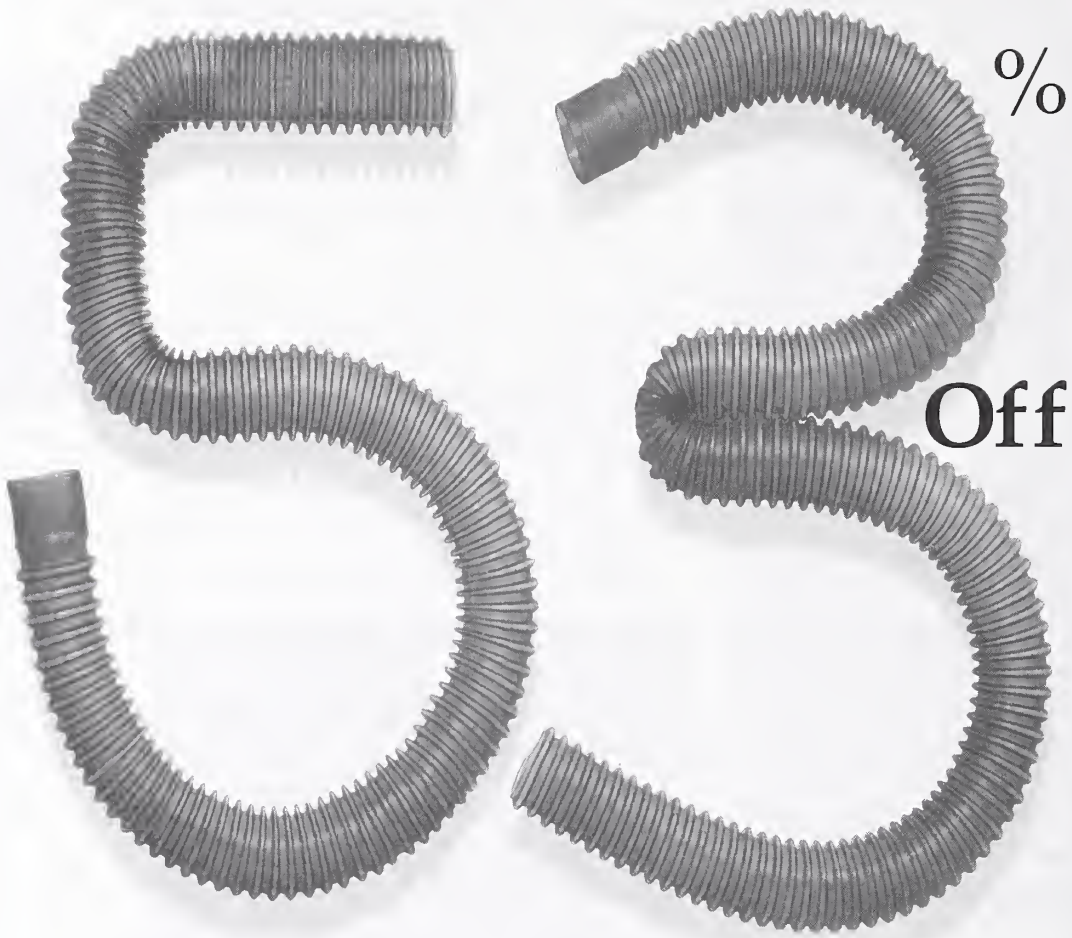
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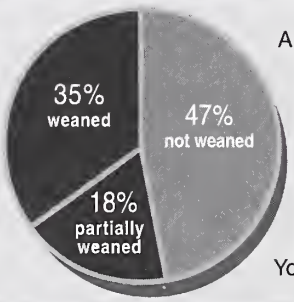
This seminar will be held at the Mercy Education Center, Fifth Street and University Avenue, Des Moines, Iowa. Parking adjacent to the Education Center.

Please contact: Department of Medical Education • Mercy Hospital Medical Center
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Legislative Affairs

IMS point of service bill introduced

The IMS point of service bill has been introduced as HF 133 with 37 sponsors from both political parties. Representative Janet Metcalf, chair of the House Commerce Committee, is lead sponsor. The bill continues to gain support and has the support of a long list of business organizations and other providers groups. The bill would require employers of 50 or more to offer to employees at least one of three options: (1) a traditional indemnity plan; (2) a managed care plan with an unrestricted provider network; (3) a managed care plan with an optional point of service feature which allows patients to self-refer to physicians outside the plan. There may be an additional cost to the patient based on the cost of administering this feature of the plan.

Insurers must offer at least one of these options to employers with less than 50 employees, but because of the difficulty most small businesses have providing health benefits at all, they would not be required to offer the choice to employees.

This bill is being viewed by legislators as balancing the cost concerns of employers with ensuring that employees have the opportunity to choose their own physicians. Ask your legislators to vote for HF 133.

Tort reform

The Common Sense Civil Justice Reform bill has been introduced in the Senate as SSB 78 and will also be introduced in the House. The IMS is a leading member of this coalition which includes the Iowa Osteopathic Medical Association, the Association of Iowa Hospitals and Health Systems, the Association of Business and Industry and others. Key provisions of the bill of interest to physicians include a cap on noneconomic damages, a reduction in the statute of limitations for minors and provisions strengthening requirements for qualifications of expert witnesses.

News at a glance

The IMS is looking for physicians who are interested in serving on state boards and advisory committees including the BME, Board of Respiratory Care Examiners, Board of Physician Assistant Examiners, Trauma System Advisory Council and EMS Advisory Council. Other committees relate to maternal and child health issues, AIDS, Medicaid reimbursement, tobacco, elder abuse, hospital surgical care regulations, etc. Some require a commitment of several years, while others are short-term and disband when their specific task is completed. Send a copy of your CV and the board or committee you would like to serve on to Becky Roorda at the IMS or call her for more information.

This bill will bring common sense back to our legal system while protecting the rights of truly injured parties to receive fair compensation. It would provide a reasonable limit of $250,000 on noneconomic damages but would allow full compensation for health care costs and lost earnings.

Physicians must let their legislators know how important tort reform is to the practice of medicine. The opponents of tort reform are fighting hard to keep this bill from going anywhere and are lobbying hard to take important provisions such as the cap out of the bill. Watch out for the red herrings being used by the opponents who are trying to convince legislators that tort reform will prevent lawsuits by victims of tobacco and big hog lots. This is simply not true and is nothing more than a desperate attempt to use these emotional issues to divert attention from the real issue.

Call or write your state senator and representative about the need for these common sense reforms!

Worker's compensation

The IMS is supporting SSB 51 by the Association of Iowa Hospitals and Health Systems to provide a mechanism for eventual payment of health care providers when there is a dispute over whether payment should be made by the worker's compensation insurer or the health benefit plan. Providers can be

continued

Legislative Affairs
continued

left uncompensated for long periods while the carriers attempt to iron out disagreements.

Utilization review

The IMS bill to require Iowa licensure of utilization reviewers is expected to be introduced as a study in the Senate Commerce Committee, but as of press time no number had been assigned to it. IM

Contacting Your Legislators

Telephone numbers during the session:

Senators	**515/281-3371**
Representatives	**515/281-3221**
Governor	**515/281-5211**

Write to them at: **STATEHOUSE**
Des Moines, Iowa 50319

You may also contact your legislators at home when the legislature is not in session. If you need your legislator's name or home address and phone number, call Cheryl Peers of the IMS staff, 800/747-3070 or 515/223-1401 (or e-mail legis@netins.net). You may access the Iowa Statehouse web site at www.legis.state.ia.us.

Clarkson Medical Lecture Series

"Nephrology Update"
Management of Acute Renal Failure

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Medical Economics

Medigap premiums rise 23% in 1996

Premiums for policies that pick up Medicare's copayments and deductibles rose sharply last year and are expected to take another upward turn in 1997. In addition, the premium spiral is driving more senior citizens out of fee-for-service medicine and into managed care.

A 35-state survey by *Families USA* concludes some companies raised premiums as much as 23%. Increases by other companies were more moderate, but premiums for almost all Medigap plans rose at least 10%.

News at a glance

HCFA is making moves toward finalizing a rule to guide Medicare payment for new technology or services. The AMA is first on a list of groups concerned that language requiring HCFA to assess the cost-effectiveness of technology could block life-saving innovations from widespread use. Government officials, however, say that the controversial provision will be deleted from the final rule when it is published.

How frustrated are physicians with the constraints of managed care? Physicians of the Medical Society of the District of Columbia recently voted to endorse single payer as a reform "option" if certain criteria are met. However, others contend the D.C. vote is not indicative of widespread physician support for a single payer system.

Basics of "incident to . . . "

During the IMS December ICN program "When Bad Things Happen to Good Physicians", several questions were raised about providing and billing for services that are "incident to" a physician's services.

"Incident to" is a concept which originated with Medicare, though other payers have begun to apply the concept also. Unfortunately, the Medicare rules and regulations about "incident to" are very lengthy and include many nuances. Because of the recent focus on this issue, IMS recommends careful attention to be sure the "incident to" rules are being followed.

Three key issues are clear. First, a non-physician providing services "incident to" a physician must have a W-2 employee relationship to the physician/physician group practice/legal entity which employs the physician *or* must be a leased employee. The provision regarding "leased" employees was not effective prior to November 1996.

Second, a physician must be present in the office *and* immediately available in order to bill office services "incident to" the physician.

Finally, in order to be "incident to" a physician's services, the physician must have seen the patient and established a plan of care. Therefore, "incident to" services should not be billed using the new patient E & M code ranges.

IMS is continuing to seek clarification of other "incident to" issues. Keep watching *Iowa Medicine* for additional information. IM

IMS Offers "Audits and Compliance" Program

The Iowa Medical Society is focusing time and resources on helping members manage the risk associated with post-payment audits by third party payers and government programs. During March, joint seminars with IH & HS "Compliance Programs: Good Preventive Medicine" will be presented in five Iowa cities. During June – August, additional programs will be presented by IMS staff. For additional assistance or information, contact Barbara Cannon or Barbara Pierce at IMS, 515/223-1401 or 800/747-3070.

DATA & TECHNOLOGY

Rural telemedicine survey

The U.S. Office of Rural Health Policy and Research recently commissioned and funded the Exploratory Evaluation of Telemedicine. The objective was to evaluate the current status of telemedicine in rural America. Some of the results were quite surprising.

For the next three years, Medicare will pay for select teleconsultations at 57 facilities affiliated with five telemedicine projects in four states (including two projects in Iowa). If successful, Medicare will decide whether to routinely pay physicians for teleconsultations with Medicare patients.

Of the rural hospitals responding, 14% (353 facilities) were involved in active telemedicine programs. These were linked to 205 urban hospitals or urban-affiliated clinics. Sixty-eight percent of these respondents used telemedicine for teleradiology, and 31% did other types of telemedicine, usually interactive consults with or without teleradiology.

The average network was comprised of nine sites: two hubs (or the urban facilities), four spokes (the rural facilities transmitting data and images) and four sites that provided and received consultations. Virtually all of the programs use telemedicine for clinical and non-clinical (educational and administrative) purposes.

Low utilization, high start-up costs

Generally, utilization was low for most networks. The typical telemedicine site conducted only one clinical session per week and one to two non-clinical sessions per week. Costs to start up a program, such as acquiring equipment, were high, ranging from $134,378 for spoke sites to $287,503 for hubs. Annual transmission costs averaged $18,573 for spokes and $80,068 for hubs.

The per consult costs were also very high, coming in at $1,660 per consult, not including physician reimbursement. High start-up costs coupled with low utilization are the primary drivers of the high per usage costs.

For more information, call Ed Whitver, IMS manager of health care data and technology, 515/223-1401 or 800/747-3070.

Data security

Physicians are embracing computers in their everyday lives. While most physicians use computers to bill patients and insurance companies, many are also adding electronic medical records to their practice. Electronic processing has many benefits, but there are also risks, one of which is data security.

Significant investments are being made in information technology systems by physicians, hospitals, provider networks, health plans, etc. An electronic medium makes it possible to share data that will help provide good patient care, but this advantage could be overshadowed by the possibility that a patient's medical information could fall into the wrong hands.

Selected agencies can help secure data

Data security should be given the highest priority as health care becomes automated. Several organizations can assist medical professionals in achieving a high degree of security and confidentiality. The American Health Information Management Association has a list of safeguards that should accompany planning a computer-based patient record.

The Computer-based Patient Records Institute has recently released functional requirements for computer-based security of confidential patient records. Buyers of health care information systems could ask vendors and developers about the data security measures built into the software. The institute also sells various guidelines for establishing information security policies and programs, educating health care professionals about security and developing confidentiality statements and agreements.

The National Library of Medicine, an agency within the U.S. Public Health Service's National Institutes of Health, has also released a report for protecting electronic health information for both research and clinical uses.

Providers should utilize these resources as they migrate from paper to electronic patient information. One incidence of inappropriate access may cause irreparable harm to the patient and provider. IM

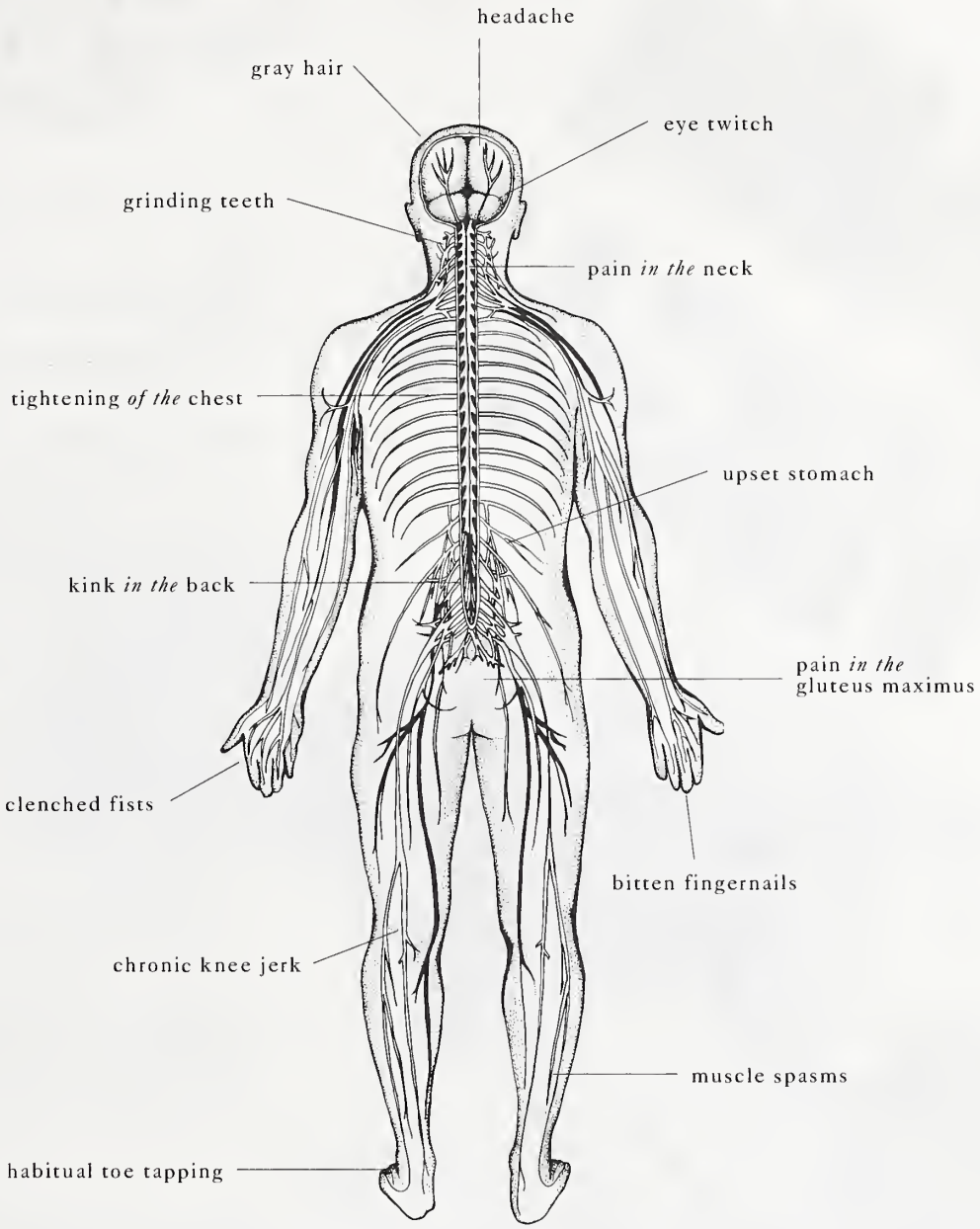


Figure 23

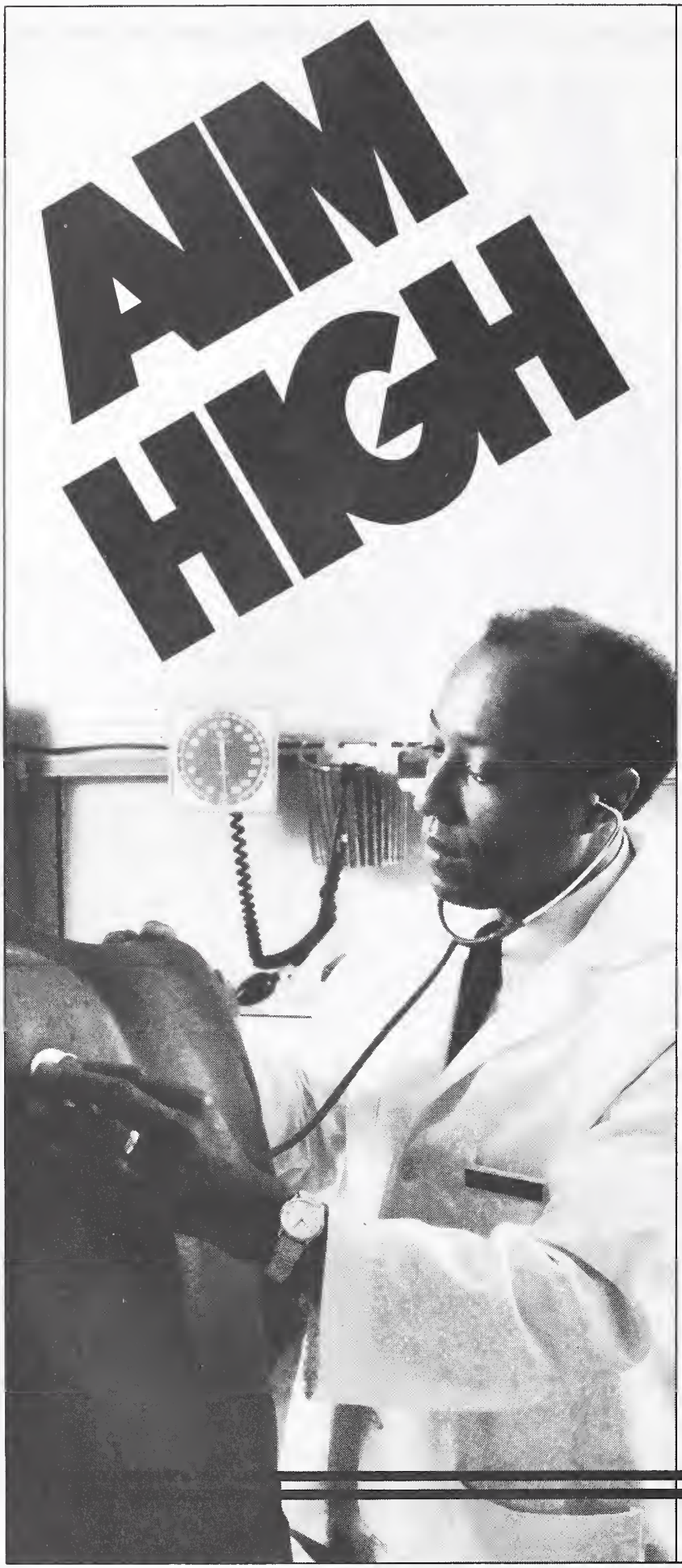
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AIR FORCE

Practice Management

New practice management staff at IMS

Barb Pierce has joined the IMS staff as practice management coordinator.

Barb has been in the health care field for 25 years and comes to IMS from Integra Health, where she was coding coordinator. She has worked extensively with physicians on coding and billing compliance issues.



Barbara Pierce has been hired as the new IMS practice management coordinator.

Barb Pierce and Barb Cannon will now be available to assist IMS members and their staff with general practice management questions.

Specific billing and payment policy questions regarding commercial insurers and other third party payers (including managed care) should be directed to Barb Pierce.

Specific billing and payment policy questions about government programs, i.e., Medicare and Medicaid (including managed care), should be directed to Barb Cannon.

News at a glance

The Iowa Department of Human Services has awarded a new fiscal agent contract for Medicaid. Beginning July 1, 1997, Consultec, Inc. of Atlanta, Georgia will perform all activities related to claims processing, provider audit, medical review, surveillance and utilization review, prior authorization of prescription drugs, third party liability, provider enrollment, provider inquiry and other services. Consultec will have offices in the Des Moines metro area. The current contractor will continue to process and receive all information until June 30, 1997.

Mary Jane Zismer is 22nd MBS graduate



Ms. Zismer, team coordinator with River Valley Health Care in Davenport, has completed the Medical Business Specialist program and is pictured above with her certificate. According to Ms. Zismer, the MBS program "shows employers that an individual strives to keep current in the ever changing health care environment". Ms. Zismer is the 22nd MBS graduate.

Practice Management Workshops for You

Quality in the Medical Office

April 1 **IMS Headquarters West Des Moines**
April 17 **St. Ambrose, Davenport**

Examines trends in quality, i.e., total quality, outcome measures, practice parameters and patient satisfaction results. Instructor: Mary Pat Wohlford-Wessels.

Resource Management

June 5 **IMS Headquarters West Des Moines**

Accounting, tax and human resource information. Instructors from Vroman, McGowen, Hurst, Clark & Smith, PC.

Specialty Coding Extravaganza III

April 29–30 **Best Western Airport Inn, Des Moines**
May 1

Oncology, cardiology, obstetrics & gynecology, E&M documentation guidelines, audit score sheets and Medicare's correct coding initiative. Instructors: Jennifer Jones, Nancy Maguire, Barb Cannon.

For more information or to register for any IMS practice management workshop, call Sherry Johnson at IMS Services, 515/223-2816 or 800/728-5398.

Practice Management
continued

Midwest Medical Insurance Company Focus on Risk Management

Documenting telephone advice: a case in point

The mother of a three-year-old called the family physician at 2:00 a.m. because her child had been lethargic and febrile for 24 hours. After taking a brief history, the physician on-call advised a trial of home treatment. He told the mother the child could be suffering from the flu, but cautioned that it might be something more significant. He instructed the mother to take the child to the emergency department of the local hospital if the fever increased or did not subside within a few hours. Several days later, the physician learned that the child had been admitted to the hospital two days after the phone conversation suffering from meningococcal meningitis. The child suffered severe brain damage and requires lifelong care. The mother sued the physician and alleged he had advised her to give the child acetaminophen and fluids and see their family doctor when he returned from vacation. The physician had not documented the telephone call and had to testify that he was sure he had given his "usual and customary" advice.

Documentation of treatment advice can prevent patient injuries and may be your only defense to a malpractice claim. To reduce your liability exposure, document:

- All advice calls, whether during office hours or after-hours. Date and time all entries.
- The symptoms being described. Use the caller's words.
- The assessment of the problem and advice or treatment given.
- The symptoms that indicate the patient or parent should call back. Use measurable terms and time frames.

For more information contact Lori Atkinson, MMIC risk management supervisor, Midwest Medical Insurance Company, West Des Moines Office, PO Box 65790, West Des Moines, Iowa 50265; 800/798-9870 or 515/223-1482.

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IOWA MEDICAL GROUP MANAGEMENT ASSOCIATION

Spring 1997 Meeting ◆ May 21–23

Des Moines Marriott Hotel

"Medical practice management is our specialty"

A few reasons why you won't want to miss this IMGMA meeting:



Alice Gosfield

◆ Keynote speaker Alice Gosfield will give a presentation on Medicare and Medicaid fraud and abuse

◆ Breakout sessions on tips for new clinic managers, Medicare rural health clinics, economic credentialing in managed care, hands-on Internet training, handling patient complaints

◆ Des Moines attorney Roxanne Conlin will address human resource legal issues



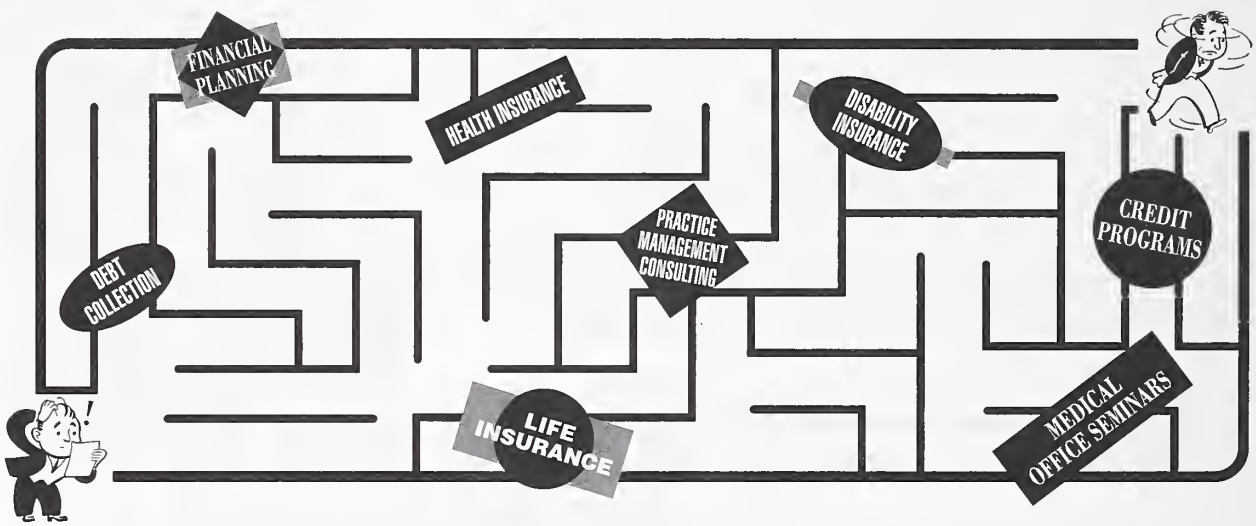
Roxanne Conlin

Dinner & Dancing

It won't be all work and no play at the 1997 IMGMA Spring Meeting. Des Moines' favorite dance band, Flip Side, will entertain after the Thursday evening banquet. Bring your dancing shoes!

For more details or to register for any part of this 2½ day meeting, call the IMGMA office at 800/728-5398 or 515/223-2816 or send an e-mail message to memserv@netins.net.

It's A Mazing The Decisions Involved In Running A Medical Practice



You're a physician and you know the complexities of running your own practice. There are many services you and your staff need to operate more efficiently. Weaving your way through all of the programs and products, however, can be overwhelming.

Sure, you could have a piecemeal approach to your needs. But why, when you could have one-stop shopping with IMS Services. With many of the services available in one location, it can make your practice operate smoother and keep you on the road to running a successful practice.

So contact IMS Services to be unmazed with all the programs and products available. For further information on any of the following, please call **515/223-2816 or 800/728-5398.**

- **Professional Liability Insurance**
- **Financial Planning**
- **Overnight Air Express Service**
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- **Workers Compensation Insurance**
- **Disability Insurance**
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- **Specialty Society Management Services**
- **Practice Management Consulting**
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- **Retirement Planning**
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Newsmakers

Awards, appointments, etc.

Dr. Jack Bristow, Sioux City obstetrician/gynecologist, has retired from medical practice. **Dr. Charles Zelnick**, Cedar Rapids Family Practice Center director, was recently recognized for his commitment to the delivery of patient education. The recognition was part of the Patient Education Week at Mercy Medical Center in Cedar Rapids. **Dr. Thomas Kline**, family practice physician and medical director of Mercy Indianola Medical Clinic, has been named the new medical director for SecureCare of Iowa. Dr. Kline replaces **Dr. Kenneth Anderson** who has moved to South Bend, Indiana to become chief medical officer for Partners Health Plan. **Dr. George Montgomery**, internal medicine, has been named medical director of Northcrest Retirement Community in Ames. **Dr. James Schlimmer** recently joined Dubuque Anesthesia. Dr. Schlimmer was previously in family practice in Waterloo. **Dr. John Pallanch**, Sioux City otolaryngologist, was recently elected to fellowship in the Triological Society at that group's 99th annual meeting in Orlando, Florida. New medical staff officers have been chosen for Mercy Hospital Medical Center, Des Moines. They are: **Dr. Douglas Koontz**, president; **Dr. Hugh Dick**, president-elect and **Dr. William Young**, secretary-treasurer. **Dr. L.C. Faber**, Dubuque, has been elected chairman of the Nominating Committee of the Board of Governors for the American College of Surgeons. Dr. Faber served as vice chairman in 1996. **Dr. Briccio Salvo**, Dubuque anesthesiologist, has retired from practice. **Dr. Nidal Harb**, cardiologist at Medical Associates in Clinton, recently lead a medical team to the Holy Land. The mission was organized by Physicians for Peace, an American-based group created to provide continuous medical education and medical care to people in troubled areas of the world. **Drs. Gina Moran, Brian Moran** and **Mark Hermann** recently became board certified by the American Board of Internal Medicine. All three physicians are with Finley Hospital, Dubuque. IM

News at a glance

Grinnell, Iowa has become only the second city in the U.S. to establish an institute dedicated to reducing the intrusive trauma of surgery. According to ***Dr. David Coster****, medical director of the Grinnell Institute for Minimally Invasive Surgery, surgeons at the institute employ techniques such as microsurgery, laparoscopy, thorascoscopy, endoscopy, sinoscopy and arthroscopy. Other institute members are* ***Drs. Robert Brebrick, Warren Bower, Victor Wilson, Russell Bandstra, James Roeder and Ronald Charles.***

Christopher Atchison*, director of the Iowa Department of Public Health, will be attending a national symposium on medicine and public health in New York on April 9. The symposium will be hosted by the National Academy of Medicine and supported by the AMA and American Public Health Association. Mr Atchison is a panel member of the Public Health and Medicine Monograph Project. The symposium will preview the findings of the monograph which will be distributed to 250,000 health practitioners, educators, students and researchers later this year.*

PHYSICIAN LITIGATION SUPPORT PROGRAM

Iowa physicians needed for start-up of new program

If you have been through the experience of a lawsuit or a malpractice claim and would like to help colleagues being sued, you might be interested in becoming a volunteer physician in the Physician Litigation Support Program. The program is being established through a joint effort of Midwest Medical Insurance Company and the Iowa Medical Society. The first step in establishing the program is to find Iowa physicians in all specialties who are willing to offer assistance, information and emotional support to colleagues who are being sued. A half-day training session will be required. Contact Lori Atkinson with MMIC, 515/223-1482 or 800/798-9870 if you are interested in hearing more about becoming a physician volunteer. The Physician Litigation Support Program will be available to all IMS members in June of this year.

Socioeconomic impact of child abuse

It is easier to build strong children *than to* mend broken men*

Child abuse has reached epidemic proportions, making it a primary public health problem affecting all segments of society. Dr. Rizwan Shah, a local expert in socioeconomic implications of child abuse, discusses the emotional and physical toll child abuse takes on both children and adults.



RIZWAN SHAH, MD
Dr. Shah is a pediatrician with Blank Children's Hospital in Des Moines.

Each year in the U.S., over three million children are reported abused. Of these, over one million cases are substantiated. Iowa has between 17,000–31,000 reports of suspected child abuse each year. In addition to physical abuse, sexual abuse, neglect and emotional abuse, Iowa's child abuse law includes exposure to illegal drugs by minors as a form of child abuse. Since its inclusion in Iowa legislation in 1990, increasing reports of drug-exposed newborns and children are filed with the court system.

Child abuse is a multifaceted phenomenon. It is also gender and ethnicity nonspecific. Often physical abuse, neglect and sexual abuse problems are found in an intergenerational fashion, linking multiple generations in a family with dysfunction associated with child abuse.

Emotional exploitation — the background of all child maltreatment and neglect — attacks the child's basic sense of self as lovable and worthy of care.

Emotional exploitation

A child's age and developmental level at the time of abuse have an important bearing on its lasting effects. Violent intrusions challenge the child's most basic assumptions about personal safety and the world as a predictable place. Emotional exploitation — the background of all child maltreatment and neglect — attacks the child's basic sense of self as lovable and worthy of care. Abuse at an early level of cognitive development is more likely to be internalized to mean the child is "bad", a feeling that is carried into future relationships.

Abused children suffer a wide range of emotional, developmental and physical problems as a consequence of the ongoing abuse cycle. Important developmental tasks of childhood such as attachment, trust, healthy self-image and cognitive functions can be hampered seriously due to crisis of self-preservation in an abusive environment.

Controlled empirical studies have increased our understanding of victimization's effects. Thus, 14-month-old abused infants were more likely to turn away from their par-

ent's attention than controls (Wasserman et al. 1983). Abused toddlers, one to three years of age, avoided peers four times more often than controls. They hit peers, verbally or physically assaulted care providers and were less likely to approach care providers in response to friendly gestures. Four-year-old abused children were more likely than controls to engage in aggressive behavior with peers (Hoffman et al. 1984).

Childhood abuse carries over to adulthood

Available research studies suggest that sexual abuse in childhood appears to increase the risk of later sexual aggression, probably for the more severely traumatized children (Longe 1982, Becker 1988). Peters et al. (1986) discussed prior sexual abuse in 3%–30% of males and 8%–38% of female sex offenders interviewed. Adolescent sex offender treatment programs have reported prior sexual abuse in 19%–47% of their clients.

Psychological sequelae of abuse in adult survivors include physical and emotional problems such as depression and suicide; borderline personality and multiple personality disorders; social maladjustments such as teen runaways, prostitution, dysfunctional relationships, sexual promiscuity, alcohol and drug abuse; and legal problems such as juvenile delinquency, violence and criminal behavior.

An association between childhood abuse and adult homelessness has not been widely explored. However, in one study, a threefold increase for homelessness was noted among women with child neglect histories.

Impact of drug abuse on child abuse

The current epidemic of drug abuse sweeping the U.S. has added to the problem of child abuse. A substance-abusing parent has a chaotic lifestyle with social and legal problems related to drug problems. Children living in such an environment are at increased risk for neglect and abuse. Secondary trauma to children occurs due to multiple out-of-home placements with long-term psychological impact. Because of the complex nature of family dysfunction in substance-abusing families, a multidisciplinary approach to the assessment of risk in such environment is recommended.

Chemical dependency to drugs is often called chemical dissociation, due to its close link with child physical and sexual abuse. Among substance abusing women, a history of sexual abuse can provide an important link toward effective treatment programs needed for such dual diagnosis.

Burden on society

Lasting effects of child abuse and neglect result in enormous human and financial costs to society. In the U.S., the estimated annual cost of caring for children seriously hurt by child maltreatment approaches $500 million. This amount doesn't include the economic cost for adult survivors of child abuse who suffer from cognitive, emotional and social impairment from long-term abuse effects.

If we intend to enter into the next century as a healthy and productive society, we must make child abuse prevention our national priority, because for the healing to begin, the intergenerational cycle of abuse must be stopped by interventions before the abuse occurs. IM

**Frederick Douglass, U.S. statesman, 1817-1895*



No one deserves to be hurt.

In the U.S., the estimated annual cost of caring for children seriously hurt by child maltreatment approaches $500 million.

To report suspected child and adult abuse, call this 24-hour, toll free hotline:
1-800/362-2178

Testifying in child abuse cases

To be believed or not believed

Testifying as an expert medical witness in a child abuse case can be a daunting prospect for any physician. Here, an Iowa physician who has testified in many courtrooms offers advice on how to deal with attorneys and how to establish your credibility as a witness.

Throughout history, society has notoriously underprotected its children, believing that children were the possessions of the parents to use or abuse with absolute impunity. Starting with recognition of the Battered Child Syndrome, coined by Dr. Kempe in 1962, medicine and law have made tremendous growths in recognizing patterns of nonaccidental injuries in children and in protecting children from receiving these injuries.

Mandatory reporting: a positive step

One of the first positive steps was mandatory reporting of suspected abuse. Physicians and other health care workers were suddenly expected to recognize and report abuse to authorities. The numbers of reported and confirmed cases have skyrocketed since these laws were enacted. About one third of reported cases are confirmed or founded.

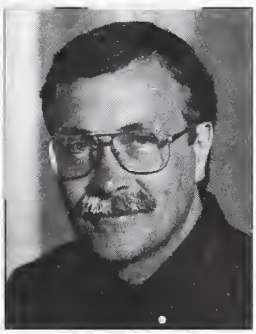
Physicians have collected signs and symptoms into recognizable patterns for centuries and have given various names to these patterns under the general term, syndrome. Calling something a syndrome is giving a medical diagnosis to that collection of findings, with the name of the syndrome often giving a clue as to its nature.

A syndrome is a medical diagnosis

For example, the Shaken Infant Syndrome is a medical diagnosis which includes at least the findings of retinal hemorrhages, subdural hematoma or other intracranial bleeding and the absence of other recognizable cause or injury. As this has been studied over the years, the characteristic signs and symptoms have become more specific, such as the location of the retinal hemorrhages in the eye fields (peripheral), other associated retinal findings (macular folds, etc.), location of the subdural hematomas (especially parafacial) and the possibilities of other findings in the skeleton or skin. We can use these terms as recognized medical diagnoses and introduce them in court as medical rather than legal conclusions.

We can use these terms as recognized medical diagnoses and introduce them in court as medical rather than legal conclusions.

This increased knowledge will separate the medical expert with a valid expert opinion from other types of "expert" witnesses.



THOMAS BENNETT, MD
Dr. Bennett is Iowa's State Medical Examiner.

Our role as medical experts

Our role as a medical expert is to help the court through educating the jurors and/or judge about whichever issues are being discussed in that case at that time.

We don't help anyone by being biased or trying to help whichever side calls us to testify. Sometimes the court may only use us as fact witnesses, telling the facts we know but not offering expert opinions. Whether as fact witness or expert witness, we must enter the court well prepared, both about the case at hand and about the field of medicine involved. Preparation involves your training, experiences, readings and consultations.

My policy is to talk with any attorney who wishes to question me, whether prior to testifying or after. I let them see whatever is in my file so there are no surprises for either side.

My files include photographs, diagrams reports and memos that I have generated. Preparing the attorneys is almost as valuable as preparing yourself. Ask them questions and prepare answers for any questions they may ask you in court.

In court, a grand jury or a deposition

There are three places you may be called to testify — grand jury, depositions and in court. In general, you should prepare the same for each, but the rules and stresses differ greatly.

Grand jury testimonies are quite easy and enjoyable, for there is only one side asking questions and you can talk with everyone in the room.

Depositions are the most stressful, for the opposing counsels can try out their arguments over your carcass and stray into areas the judge would not allow them to venture into otherwise, but you are expected to answer all their questions anyway, if you can.

Lastly, but most important, is the courtroom. Follow these general rules:

•Listen to the entire question before answering.

•If you don't understand the question, ask for it to be repeated or rephrased.

•Answer what is asked. Don't go into a rambling lecture.

•Educate the jury with the facts and the basis for rendering opinions, *prior* to giving your own opinion on the matter. Juries want to be taught. Teach them *why* you reached that conclusion.

•Offer opinions, and offer the relative strength of those opinions:

- •Absolute certainty = 100% certainty;
- •Reasonable medical probability = 50-90% convinced;
- •Possibility = 25-50% chance of occurring;
- •Speculation = 0-25% chance of occurring.

Only offer opinions if they are at least probable or relatively certain, as above.

•Don't be afraid to say, "I don't know", or "that is outside my area of expertise". It gives you credibility to stay in your field.

•Use plain English, not medicobabble. Use inches and pounds, etc.

•Some lawyers like to be confrontational. Be cool, not cold or hot. Think of them as a best friend who is a little slow at times. You would show patience to a friend.

•Look at the jury and the judge when you testify. The attorneys don't count — they don't make the decision.

•Be yourself.

You may become a better communicator

Since the adversarial system in our courts will challenge any opinion you give, testifying in court is a great way to find out all the things you should have done. Don't take it personally. It will stimulate you to become a better communicator, investigator and physician. IM



No one deserves to be hurt.

Don't be afraid to say, "I don't know", or "that is outside my area of expertise". It gives you credibility to stay in your field.

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Specialty Coding Extravaganza III

April 29, 30, May 1

Best Western Airport Inn
1801 Army Post Road
Des Moines, Iowa

April 29
- Oncology–Terrace Room 1
- Advanced OB/GYN–Terrace Rooms 2 & 3

April 30
- Medicare Correct Coding Initiative–Terrace Room 4

May 1
- Cardiology–Terrace Room 1
- E & M Documentation Code Guidelines/Audit Score Sheets Terrace Rooms 2 & 3

IMS **Specialty Coding Extravaganza III** will feature Oncology, Cardiology, Advanced Obstetrics and Gynecology, E&M Code Documentation Guidelines and Audit Score Sheets and Medicare's Correct Coding Initiative. Instructors will give you the latest updates and information on these specific topics. This is an opportunity for you to get answers that will solve coding problems unique to your specialty.

Barbara Cannon, Iowa Medical Society, will speak on Oncology and E & M Code Documentation Guidelines and HCFA Audit Score Sheets; Nancy Maguire, St. Anthony's, will present Medicare's Correct Coding Initiative and Cardiology Coding; and Jennifer Jones, Practice Management Consulting, will instruct Advanced OB/GYN Coding.

Seminar time is 8:30 a.m. to 4:30 p.m. (except for E & M Documentation Guildelines/Audit Score Sheets which is a half day program and will be presented at 9:30 a.m. – 12:00 p.m. and 1:00 – 3:30 p.m.). Lunch will be provided for all day programs.

REGISTRATION FORM

Complete this form and mail it along with your check or money order to:
IMS Services, Attn: Seminars, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599

NAME(S) _____

OFFICE/CLINIC _____

ADDRESS _____

TELEPHONE _____ FAX _____

SEMINAR/COST: _____	April 29	Oncology	$99 member/$198 non-member
_____	April 29	Advanced Ob/Gyn	$99 member/$198 non-member
_____	April 30	Medicare Correct Coding Initiative	$99 member/$198 non-member
_____	May 1	Cardiology	$99 member/$198 non-member
__ a.m. __ p.m. _____	May 1	E & M Documentation Guidelines/Audit Score Sheets	$49 member/$98 non-member

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Living trusts . . . Do you need one?

PERSONAL FINANCIAL STRATEGIES

In recent years, there has been a significant amount of hype and press regarding the need for revocable living trusts (RLT). This hype has been predicated on the fear of probate. The truth of the matter is that revocable living trusts are no panacea, but they are very useful in certain situations.

Revocable living trusts are independent entities which are controlled by a trustee. You can be named the trustee of your own trust, thereby controlling the assets while you are alive. This means you can trade stocks, invest in mutual funds and buy and sell real estate. You also have the power to revoke the trust or change it at any time.

The main reason for the highly publicized promotion of the RLT has been the fact that all property in the trust passes outside of your will, therefore avoiding probate. Probate is the court-supervised process used to collect and distribute a person's assets at death. The actual meaning of probate is to "prove the will". Promotions of living trusts have played upon this many times by exaggerating the hassles and costs of probate. However, in Iowa, probate costs are approximately 2%, which makes Iowa one of the lowest probate cost states in the country. Therefore, the cost factor is minimized in deciding whether a revocable living trust makes sense for you.

Revocable living trusts are no panacea, but they are very useful in certain situations.

There are other factors, however, which may cause an RLT to make sense:

Privacy — Probate makes a person's estate open to public scrutiny. If you want to ensure privacy of your estate, then an RLT makes sense.

Family struggles — Probate allows for someone to contest your will. An RLT can go a long way to ensure that your estate is distributed the way you want it to be with minimal, if any, contesting.

Potential incompetency — Incapacitating illness or injury can create significant problems and costs for a person and their family in making decisions regarding assets. An RLT specifies what you want to happen and who you want to step into the decision-making process on your behalf.

Multi-state property — If you own real estate in more than one state, then probate will be necessary in all of those states. An RLT will eliminate that hassle and therefore reduce costs to the estate.

Only after consideration of these issues does cost become a factor. If potential probate costs exceed the cost of establishing a trust and the above issues are prevalent, then it may make sense to pursue establishing an RLT. The key to this decision-making process is to know the facts rather than acting on hype. IM



JERRY FOSTER

Jerry Foster is the founder and president of Foster Capital Management, a fee-based financial advisory firm endorsed by the Iowa Medical Society. Mr. Foster can be reached at 1-800/798-1012.

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No one deserves to be hurt.

Child abuse and the physician

● *Randell Alexander, MD*

It has been 35 years since Dr. Henry Kempe and his colleagues published "The Battered Child Syndrome" in the *Journal of the American Medical Association* (Kempe et al. 1962). Since that time the recognition and reporting of child abuse has dramatically increased. In 1995, there were approximately three million child abuse reports nationwide, one million of which were confirmed (Lung and Daro 1995). The U.S. Advisory Board on Child Abuse and Neglect estimates that there are at least 2000 children who die each year from child abuse (U.S. Advisory Board on Child Abuse and Neglect, 1995).

A number of national conferences are held each year on the subject. There are over 5000 members in the American Professional Society on the Abuse of Children (an interdisciplinary association), over 500 pediatricians in the Section on Child Abuse of the American Academy of Pediatrics and a state child death review team in nearly every state (including Iowa). In Iowa, as elsewhere, there are specialized centers and individuals who deal with various aspects of child abuse. All this increased recognition and specialization is impressive, so is the role primary care physicians and others play in protecting children (Reece 1994).

Definition and types of child abuse

"Child abuse" refers to all categories of abuse and neglect. Medically, child abuse can be defined as any interaction or lack of interaction by a caregiver which results in nonaccidental harm to a child's physical, emotional, or developmental state. To meet this definition, the individual must be under 18 years old, abused or neglected by a caretaker and have some type of harm as a consequence.

In Iowa, there are six legally defined types of child abuse:

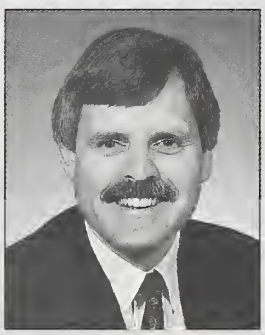
Denial of critical care (neglect) — This is the most common form of child abuse accounting for nearly 50% of reported cases, but probably present in most child abuse circumstances. Sub-categories include: denial of adequate food, shelter, clothing, medical/dental care or necessary mental health care; failure to meet the emotional needs necessary for normal development; failure to provide proper supervision which a reasonable and prudent person would exercise under similar facts and circumstances; failure to provide proper supervision thereby placing a child in a situation which endangers life or health; or failure to provide proper supervision by cruelly or unduly confining a child (includes unauthorized and/or medically unwarranted sedative medication). Neglect accounts for about half of all child abuse deaths and is perhaps the most insidious and devastating form of child abuse.

Physical abuse — This is the second most common form of child abuse. About 20–25% of all child abuse reports consist of physical abuse, usually in the form of skin injuries. Severe forms of child abuse such as Shaken Baby Syndrome are relatively uncommon, but will receive more medical attention than minor bruising which may not require physician involvement.

Medically and legally, if there is a significant injury without a satisfactory explanation it is child abuse. Contrary to those who misunderstand or misrepresent, spanking is not physical abuse. However, it is child abuse if a child is struck and an injury results. The term "spanking" does not include injury. The difference is between physical discipline and a beating. Physical abuse accounts for the other half of child abuse deaths.

Sexual abuse — Although sexual abuse is responsible for only about 14% of all substantiated child abuse reports and is not fatal (absent HIV infection), it has powerful emo-

The IMS Education Fund has designated this article as the Henry Albert Presentation Award for March 1997.



Randell Alexander, MD
Dr. Alexander is a professor in the Department of Pediatrics at the University of Iowa Hospitals and Clinics, Iowa City, Iowa.

Child abuse and the physician

continued

tional and developmental consequences. Studies indicate approximately one in four women and one in six men have some history of sexual abuse during their childhood. Genital examination shows abnormalities in only 20% of reported sexual abuse cases. In part this is because there is nothing to see if a child is fondled and because genital tissues often heal rapidly and well. Physicians who perform complete physical examinations of children should include genital inspection as a routine. This not only is for the child's health, but helps the physician to understand what is normal and what is abnormal. Done in a relaxed style, such examinations are easily tolerated by nearly all children.

Mental injury — This refers to a mental health problem in a child which is caused by a caregiver. Adjustment and anxiety disorders are frequent manifestations in this category.

Presence of illegal substances in the child — This refers not only to newborns who test positive for the presence of illegal substances (e.g., marijuana, cocaine, methamphetamine, etc.), but older children who may have acquired drug exposure by the actions of a caregiver. Passive exposure to drug smoke (e.g., crack) is the primary mechanism. About 4% of all newborns test positive for cocaine and about 5% of pediatric urine samples (Bateman and Heagarty 1989; Chasnoff et al. 1992). History is the most important indicator as symptoms are present in only about 10% of cases (M. Moskal, personal communication).

Child prostitution — This is a self-explanatory and very rare category.

Reporting responsibilities

Any person may report child abuse and has immunity from criminal penalties or lawsuit as long as the report is in good faith (e.g., not made for the purposes of extortion). In fact no physician in Iowa has ever been prosecuted or successfully sued for making a child abuse report. Physicians are mandatory reporters of child abuse. Along with many other professionals who examine, attend or treat children, physicians must make a child abuse report when reasonably suspected. Proof is not required and is too high a standard. The physician is not the judge or jury, but by making a child abuse report is stating that at least there is a suspicious circumstance which requires further investigation.

Failure to report child abuse when colleagues would have done so is a serious misdemeanor (substantial fine and/or jail). This has not occurred in Iowa. However, some physicians have been sanctioned by the Iowa Board of Medical Examiners for failure to report child abuse. For failure to report child abuse, multi-million dollar lawsuits have been brought against physicians and won. When in doubt, report.

Oral and written reports to DHS

Iowa law requires that an oral report to the Department of Human Services (DHS) be made within 24 hours. Within 72 hours a written report must be made. Many hospitals have forms for this purpose, as does DHS. A letter outlining the individuals involved and the circumstances that cause you suspicion will suffice. Upon receipt of your oral report, DHS is supposed to respond to the child's location within 24 hours; one hour if the abuse is serious. At the conclusion of the investigation, the DHS worker and supervisor will decide whether the report is founded, unfounded or undetermined (cannot tell either way). DHS has the authority to obtain any record it needs for its investigation, including all medical records.

The Department of Human Services should provide feedback about the outcome of the investigation. If it is unfounded and the physician feels that this is wrong, an appeal can be made to DHS. If the investigator will not change his/her determination after further discussion, try to call the supervisor's supervisor as a starting point. Calls to the county attorney and/or the judge may help. Above all, continue to support the child and the family as best as possible.

Training

Since 1985, Iowa law has required that all mandatory reporters and physicians who regularly provide primary care to children, must receive two hours of training every five years on the identification and reporting of child abuse. New physicians must receive such training within one year of employment. Training is provided at most hospitals. The Iowa Medical Society is updating a medically-

oriented training videotape which will be available for continuing medical education credits this summer. DHS also has a training videotape. The law makes no restriction about what constitutes sufficient training nor are there defined sanctions. Informal legal opinion is that failure to obtain such training could intensify legal sanction against physicians who failed to recognize or report child abuse.

One feature of the law often overlooked is that the employer is responsible for training or providing the training of any employee who is a mandatory reporter. Because all nurses are mandatory reporters, all physician employers regardless of specialty must see to it that the nurses receive this training. This is true even if the physician is not required to receive such training him/herself. Note that some of the other categories of mandatory reporters include: psychologists, dental hygienists, paramedics and emergency medical technicians.

References

References are available from the author or the editors of *Iowa Medicine*. IM

Child abuse case report

● *Mesrob Der Yeghiaian, MD*

This is a brief report of a case encountered at Blank Children's Hospital in Des Moines one year ago.

A 4-month-old, previously healthy female child was transported from a referring hospital emergency department with seizures and respiratory arrest possibly secondary to aspiration of formula.

She was transferred to a local emergency department by paramedics. It was related that she had vomited, choked while feeding and then quit breathing. It was unclear as to whether or not the child was holding the bottle or if the bottle had been propped, but the child was not being held during the feeding.

The informant reported that the child stopped breathing and was "blue" for an estimated five to 10 minutes. The neighbors tried to give the child some sort of CPR that was ineffective.

There was no history of any upper respiratory infection, fever or diarrhea.

The paramedics found the child apneic, cyanotic and formula was running out of her mouth and nostrils. She was subsequently intubated without incident. There was no formula in the posterior pharynx or in the endotracheal tube post-intubation. Brachial pulse was palpable, therefore no chest compressions were required.

On arrival to the emergency room some irregular respiratory and seizure activities were apparent.

Laboratory findings were as follows: venous gas pH 7.30, pCO2 29, pO2 55; bicarbonate 15 mEq/L; BE -10; white blood count 17,900; hemoglobin 9.3 gm/dl; hematocrit 28.7%; normal indices; platelets 552,000; serum sodium 135 mEq/L; potassium 3.7 mEq/L, chloride 103 mEq/L, BUN 7 mg/dl, creatinine 0.7; PT 11.8, PTT 26; normal liver functions.

In the PICU, the patient required mild hyperventilation and phenobarbital to control possible cerebral edema and seizure activities.

Head and neck examination showed the anterior fontanelle to be open, soft and flat. Fine petechia were noted on her face and neck area. Eye examination revealed pupils equal and reactive to light; extensive bilateral retinal hemorrhage were noted and no optic disc edema.

Neurologically, she was responsive to stimulation with a Glasgow Coma Score of 7. Deep tendon reflexes were hyperreflexic with clonus. A head CT scan showed no intracranial hemorrhage.

The skeletal bone survey revealed acute bilateral wrist fracture (no callus formation), a buckle fracture of the distal radius and corner fracture of the ulnar metaphysis. The nature of the wrist injuries was more consistent with exogenous trauma. The electroencephelogram was abnormal with diffuse slowing and irregular activity.

The child's symptomatology and presentation was felt to be consistent with Shaken Baby Syndrome. The patient required mechanical ventilatory support for six days.

At the time of discharge from the hospital, the patient was blind, required phenobarbital for seizure activity and had spastic quadriplegia.

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Boston, Massachusetts

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The Breast Center
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Armando E. Giuliano, M.D.
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May 2, 1997

No need for axillary dissection - Modifications of traditional therapy as a result of declining size from mammographic screening - Locally advanced breast cancer - Stereotactic guided percutaneous biopsy - Comparison of stereotactic and ultrasound guided percutaneous breast biopsy - Bone marrow transplant - Sentinel lymphadenectomy staging of breast cancer - Technical aspects of sentinel lymphadenectomy - Genetics of breast cancer - Breast ultrasonography for the surgeon, by the surgeon: Physics, principles and instrumentation for normal breast ultrasound - Diagnostic and interventional breast ultrasound

May 3, 1997

Morning Session:
Health systems of the future - Partnering with physicians - Update of Iowa's trauma system - Education of a surgeon

Afternoon Session:
Presentation of surgery resident competition award papers - Presentation of papers by members of Iowa Academy of Surgery (topics TBA)

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Child violence is not a new problem



No one deserves to be hurt.

There shall not be found among you anyone that maketh his son or his daughter to pass through the fire. This admonition from Moses to the people of Israel was in response to the Ammonites who worshiped Molach, their national deity. Their rite of human child sacrifice consisted of forcing children to pass between two lines of fire as a kind of consecration and then sacrificing them to that deity.

Violence among children and against children is foremost in our concerns now and centuries ago. The barbaric attitudes seem never to cease. Actions as we become aware of them through the passage of time seem inconceivable; that the perpetrators could become so cruel. Yet our problems of modern society are ages old; in some instances less heinous. We learn each day of infants and children being tortured, either directly or by neglect. Yet in the mid-1800s infants were cast upon dung heaps on the streets of London . . . either already dead or left to die because of not being wanted. Others were secretly left at the gates of foundling homes.

In the mid-1800s infants were cast upon dung heaps on the streets of London because they were unwanted.

We know of the plight of small children used as slave labor under the act of serving apprenticeships. Unfortunately, this is a practice still perpetuated in some countries. Child labor laws as we have in the United States are not a part of the culture of some countries. Yet, American business enterprises foster such child labor by importing the products of their slave labor for use by Americans. And Americans buy for the sake of better prices.

Gang culture is not new. In the 1600s school children in France were armed. The youngest children from the age of five carried swords. School officials declared disciplinary regulations regarding firearms or swords in the classrooms. Even without weapons, violence occurred among children. Past records tell of student gangs beating instructors, of student strikes and mutinies, revolts and even pickets. In England, during the 17th century uprisings occurred at Winchester, Rugby, Marlborough and Eton.



MARION ALBERTS, MD

Unfortunately, our present century has had a resurgence of violence. Children are abused, become violent and our social structure seems to promote violent behavior. Laws are passed, but violations go on unabated. Everyone is involved . . . the perpetrators, the victims, those who pander to the violent behavior, promoters of violence (television, video games, books, guns and drugs).

Life is too precious to be tarnished by inhumane behavior. We must work together to foster a better society. To borrow an old saying: "If it is to be, it's up to me." IM

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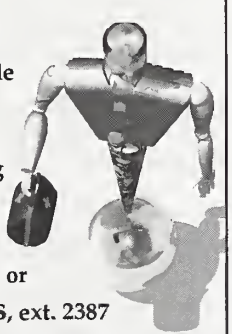
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Cedar Rapids 52403
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Randall S. Brenton, MD
James L. Dummett, MD
Mick E. Vanden Bosch, MD
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P.O. Box 1877
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515/423-8861

(Continued next page)

Professional Listing Rates

Physician members of the Iowa Medical Society may advertise in this directory. Monthly rates are as follows: $3.00 per line. Billed yearly. May be prorated. Send or fax copy to Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

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Martin S. Rosenfeld, DO
Teri S. Formanek, MD
Stephen M. Naruto, MD
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Donna J. Bahls, MD
Jill R. Meilahn, DO
Jacqueline M. Stoken, DO
Kurt A. Smith, DO
PODIATRIC MEDICINE & FOOT SURGERY
Dennis A. Kessler, DPM
411 Laurel, Suite 3300
Des Moines 50314
515/247-8400

Otolaryngology

Dubuque Otolaryngology-Head & Neck Surgery, PC
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Craig C. Herther, MD
Thomas J. Benda, Jr., MD
310 North Grandview Avenue
Dubuque 52001
319/588-0506

Iowa ENT, PC
Thomas A. Erieson, MD
Steven R. Herwig, DO
Mark K. Zlab, MD
1-800/248-4443
1215 Pleasant, Suite 408
Des Moines 50309
515/241-5780
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Perry, Newton, Oskaloosa, Knoxville

Otologic Medical Services, PC
Guy E. McFarland, MD
Thomas F. Viner, MD
Douglas E. Dawson, MD
Thomas A. Simpson, MD
540 E. Jefferson, Suite 401
Iowa City 52245
319/351-5680
1-800/642-6217
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Satellite Clinics: Washington, Mt. Pleasant, Muscatine, Fairfield and Leon

Iowa Head and Neck Associates, PC
Robert T. Brown, MD
Eugene Peterson, MD
Richard B. Merrick, MD
Robert R. Updegraff, MD
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Des Moines 50312
515/274-9135

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309 East Church
Marshalltown 50158
515/752-1566

Lakeview Medical Park
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West Des Moines 50266
515/224-9533

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516 South Division Street
Cedar Falls 50613
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Phillip A. Linquist, DO, PC
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515/244-5225
Ear, Nose and Throat Surgery, Facial Plastic Surgery, Head and Neck Surgery

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Iowa Medical Clinic Outpatient Pain Treatment Center
James R. LaMorgese, MD, FACS, Neurosurgeon, Medical Director
Ginni DeWees, RN, Program Director
600 7th Street SE
Cedar Rapids 52401
319/399-2013
Neurology, Psychiatry, Anesthesiology, Rheumatology

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Des Moines Perinatal Center, PC
Neil T. Mandsager, MD
Jeffrey Boyle, MD
3408 Woodland Avenue, Suite 302
West Des Moines 50266
515/222-3060
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Genetic Counseling
Amniocentesis and CVS
Antenatal Testing
High-Risk Obstetrical Management
High-Risk Deliveries

Physical Medicine & Rehabilitation

Rehabilitation Medicine Associates
Younker Rehabilitation Center
1200 Pleasant
Des Moines 50308
515/241-6434

2600 Grand Avenue, Suite 102
Des Moines 50312
515/283-1570

Pulmonary Medicine

Chest, Infectious Diseases & Critical Care Associates, PC
Roger T. Liu, MD
Steven G. Berry, MD
Donald L. Burrows, MD
Michael Witte, DO
Gerard A. Matysik, DO
Donald R. Shumate, DO
James M. Dy, MD
1601 NW 114th, Suite 347
Des Moines 50325-7046
24 Hour 515/224-1777

Vascular Surgery

Iowa Heart Center
Alan R. Koslow, MD
Laurie H. Kuestner, MD
411 Laurel Street, Suite 2250
Des Moines 50314
515/243-1010

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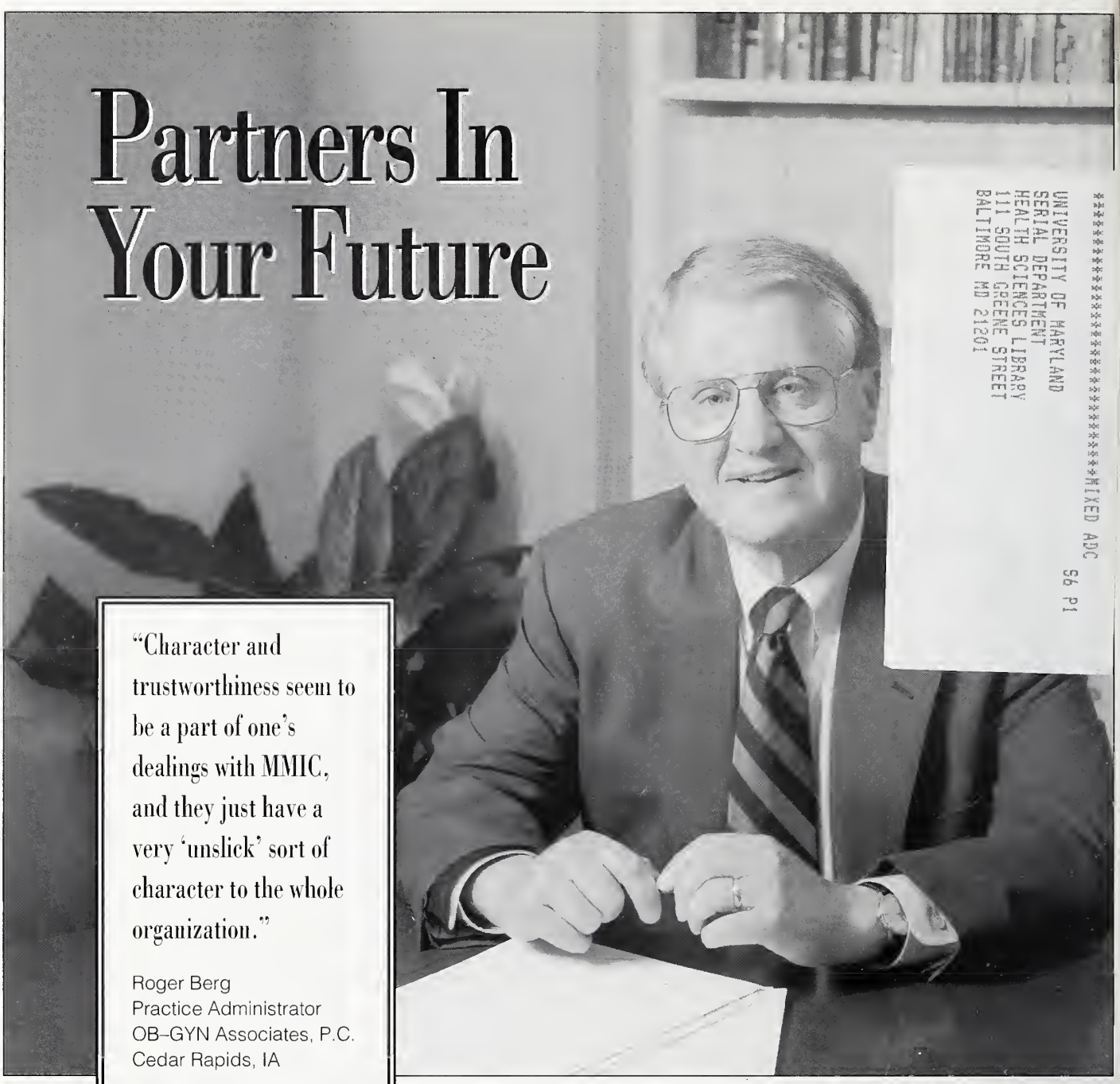
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Iowa Medicine

JOURNAL OF THE IOWA MEDICAL SOCIETY | APRIL 1997

STACKS

STACKS

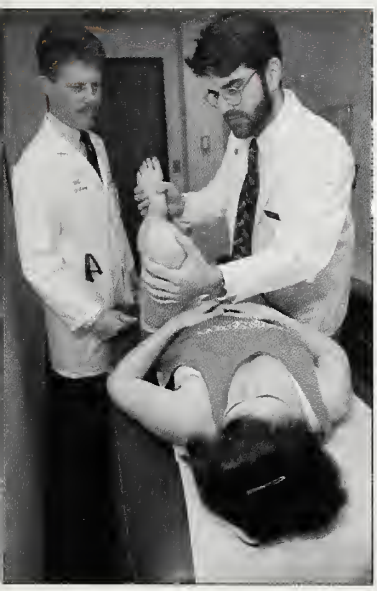
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UNIVERSITY OF IOWA
COLLEGE OF MEDICINE
ANNUAL ISSUE



Telemedicine at UI makes for better patient care

See page 148 for new ways telemedicine is being used

First ever mini-med school at UI (see page 151)

Lay people participate in a six-week course on the latest clinical advances and the science behind medicine

STACKS

Rx for a good night's sleep: diagnosing and treating sleep apnea *See page 159*

1997 Iowa Legislature

See page 140 for details on which bills survived funnel day

This issue is dedicated to Richard Caplan, MD, retiring UI professor and longtime* Iowa Medicine *columnist. See pages 163 & 165 for a tribute and farewell message.


Ease the pain!
Is this your take on Managed Care?
I see you had your first run in with managed care. Yes, managed care is all that and more. But the bottom line is this: if you don't know how to work within the framework that managed care operates, you're going to lose patients. Not to some unknown disease but the doctor who saw what was coming and prepared himself for managed care.
Strategic Health Care Systems will provide you with the resources and knowledge that will enable you to successfully operate within this evolving market. You'll learn what's expected of you, the necessary procedures to follow, and how to maneuver in managed care to reduce costs, increase productivity and income, and improve your quality of care.
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Strategic Health Care Systems today!
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IMS *DEADLINE* news

April, 1997

Late-breaking news of interest to Iowa physicians

●**AS OF PRESS TIME, IMS LEGISLATIVE STAFF AND LOBBYISTS,** supported by legislative contacts from members, were working hard to amend the reduced statute of limitations for minors to HF 693 in the Iowa House. The amendment by Clyde Bradley and others provides that lawsuits for medical malpractice allegedly committed on a minor under age six must be commenced prior to the minor's eighth birthday.

●**A GROUP OF 50 CEDAR RAPIDS PHYSICIANS**, members of Physicians Clinic of Iowa, has ended an agreement with Heritage Advantage and Unity Choice after failing to negotiate a new contract, reports the *Cedar Rapids Gazette*. In early March, PCI sent a letter to patients informing them that managed care contracts have ended. According to a spokesperson for St. Luke's Hospital – a partner in Unity Choice – the dispute centers on "fees and plan design". All sides are expressing hope that a new agreement can be reached.

●**THE IOWA PSYCHIATRIC SOCIETY** has sent a letter to its membership urging them to oppose a bill passed by the Iowa House which would allow employers or prospective employers to require random drug testing. The IPS called the measure an invasion of privacy and questioned an employer's right to know whether an employee is on prescription medication "since discrimination, either intentional or unintentional, could result from this knowledge".

●**THE DEPARTMENT OF HEALTH AND HUMAN SERVICES** has sent a communication to IMS and other state medical societies explaining the Clinton Administration's position regarding California Proposition 215, medical use of marijuana. According to the letter, nothing in the law prevents physicians from "discussing with patients the risks and alleged benefits of the use of marijuana to relieve pain". However, physicians who "intentionally provide their patients with oral or written statements in order to enable them to obtain controlled substances" risk revocation of their DEA prescribing authority, criminal prosecution and exclusion from Medicare and Medicaid.

●**MORE OF IOWA'S MEDICAID-ELIGIBLE CHILDREN** are receiving immunizations than ever before, according to a report from the Iowa Foundation for Medical Care. An IFMC study showed that nearly 71% of children received immunizations for DPT, OPV, MMR and Hib by age two.

●**PHYSICIANS WHO PROVIDE PRENATAL CARE** to pregnant minors will be required by a new Iowa law to offer the opportunity to view a video to assist them in making decisions about their pregnancy. The video, which is called "You are not Alone", is being produced by the Iowa Department of Public Health and was originally scheduled to be mailed to Iowa physicians in early February. As of press time, production of the video had been delayed and the mailing rescheduled for sometime this month. This law may be modified by this year's legislature. If you have questions about this new law, call Becky Roorda at the IMS, 515/223-1401 or 800/747-3070.

●**THE AMA AND ITS ETHICS INSTITUTE** are working with the Robert Wood Johnson Foundation to develop a physician education program designed to rectify inadequacies in the quality of care available for people at the end of life. The AMA will implement a two-part program that will a) incorporate advance care planning into routine patient care activities and b) integrate palliative medicine as a beneficial and accepted care option within the physician's armamentarium.

For more information about any *DEADLINE* news item, call Chris McMahon at IMS headquarters, 515/223-1401 or 800/747-3070.

Iowa Medicine

JOURNAL OF THE IOWA MEDICAL SOCIETY APRIL 1997 / VOLUME 87 / 4

About the Cover

This special issue is dedicated to the University of Iowa College of Medicine and UI professor Dr. Richard Caplan, longtime Iowa Medicine *columnist. Dr. Fred Dick, professor of pathology (top photo), is pictured with medical students and Dr. George Lawry, professor of internal medicine, observes a student's examination of a simulated patient.*

There's still time to register for the April 18 IMS Scientific Session "Journey into cyberspace". Call Becky Bales today at the IMS, 800/747-3070. You won't want to miss this excellent full-day program.

Editorial Board

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How do we know whether knowledge is being effectively transferred?
William McMillan, MD, IMS president

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Lots of web sites for the automobile enthusiast; other hot sites for health, travel, the arts

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Dean Robert Kelch, UI College of Medicine, discusses the relevance of the Hippocratic Oath for today's medical students.

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Telemedicine's role in UI statewide service 148

Researchers at UI College of Medicine hope technology can improve patient care while the College continues its partnership with Iowa physicians and communities.
C. Lindon Larson

Lay people go to medical school 151

UI College of Medicine offers a six-week mini-med school for community members.
Vera Dordick

Rx for a good night's sleep: diagnosing and treating sleep apnea 159

Advances are being made in diagnosing and treating the millions of Americans suffering from sleep apnea and other sleep disorders. *Vera Dordick*

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Measuring effective learning

This month's issue is dedicated to medicine's teachers in our state. This includes all physicians because at least half the healing arts is teaching our patients, our colleagues and ourselves. Our knowledge is worthless until we give it away at a price which should be determined by ethics, not business.

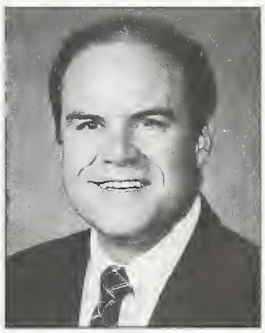
This has been a year of great learning for me, the most formal of which is that we in medicine have a maturing mechanism for graduate education. The educational objectives are usually nebulous (to attract a larger audience). The methods of information transfer are mass transit (more economical). The method of certification (posttest) is usually inadequate because of the need to have everyone get the CEUs they paid for! Consider surgical technique where a few hours of lab (hopefully with cadaver dissection) is supposed to confer the ability of the most skilled surgeon. No one's surgeon is below average! Perhaps this was the origin of the phrase "learning curve", an expression used to describe the period of time and number of cases it takes to get complications to an acceptable level.

Would it be heresy to suggest the learning curve be restricted to a training institute or a closely supervised training period in order to avoid or control as much as possible those complications? Is there good scientific evidence for centers of excellence, limiting certain procedures to that setting if the outside surgeon doesn't meet frequency of procedure criteria or the patient surpasses the severity of illness criteria?

I suggest that consumer advocate groups or referring physician groups maintain outcome and satisfaction data on all consultants in a community. These data should be readily available to patients in a form to support decision-making. Secondly, I challenge each physician in Iowa to scientifically evaluate their own practice and be able to prove to anyone the level of accuracy, inclusion and competence their practice maintains. A measured change in these descriptors can demonstrate effective learning. But always there is change in our skills, in ourselves and most certainly in our patients—their jobs, their health status and their support systems.

Our knowledge is worthless until we give it away at a price which should be determined by ethics, not business.

We cannot afford the luxury of not knowing whether our educational systems effectively transfer knowledge and skill. Only when we're at our best can we concentrate on the humanity we serve and the role our God asks us to play for our families, church, practice and community. Only when we truly know ourselves may we help others. IM



William McMillan, MD
IMS President

IOWA MEDICAL GROUP MANAGEMENT ASSOCIATION

Spring 1997 Meeting ◆ May 21–23

Des Moines Marriott Hotel

"Medical practice management is our specialty"

A few reasons why you won't want to miss this IMGMA meeting:



Alice Gosfield

- Keynote speaker Alice Gosfield will give a presentation on Medicare and Medicaid fraud and abuse

- Breakout sessions on tips for new clinic managers, Medicare rural health clinics, economic credentialing in managed care, hands-on Internet training, handling patient complaints

- Des Moines attorney Roxanne Conlin will address human resource legal issues



Roxanne Conlin

Dinner & Dancing

It won't be all work and no play at the 1997 IMGMA Spring Meeting. Des Moines' favorite dance band, Flip Side, will entertain after the Thursday evening banquet. Bring your dancing shoes!

For more details or to register for any part of this 2 1/2 day meeting, call the IMGMA office at 800/728-5398 or 515/223-2816 or send an e-mail message to memserv@netins.net.

New on the Net

Crazy about cars? Try the Net!

Searching for information about automobiles used to mean sorting through books and magazines at the bookstore. Now the same resources are available on the Internet.

Find out what your used car is worth from "Kelley's Blue Book", the long-standing resource for prices on used automobiles. Simply choose the specifications of your car and wait for Kelley's to quickly report what a dealer might offer you for a trade-in price. *http://www.kbb.com*

If you're looking for the latest reviews on the new 1997 models, check out "Edmund's Automobile Buyer's Guides". Edmund's also lets you learn what the dealer paid for a car or truck, including costs for each option. For those who are uneasy about haggling with dealers, Edmund's offers great advice how to get what you want at the auto dealership. *http://www.edmunds.com*

Another helpful site is Microsoft's "CarPoint". While the site charges a fee for the most detailed information about a car's features, you can find out additional information about insurance rates and estimated repair and maintenance costs for specific models. *http://carpoint.msn.com*

If you are interested in taking a look at marketing information on new cars, go directly to the automakers' sites. Every imaginable automaker has numerous sites online marketing new models. For a complete listing, visit "eAuto". Its site links you to all the automakers' sites. *http://www.eauto.com*

For the adventurous auto shoppers, consider skipping the dealership and shopping for your new auto online. How this works is you tell the virtual dealer what car you want and a dealer in your area will call you with a price quote. "Auto-By-Tel" is one of these car-buying sites. *http://www.autobytel.com*

See IMS Internet Hints on the IMS web site for more ideas and links for researching automobiles on the Internet.



Linking IMS physicians to the information they need

Hot sites

WellnessWeb: "WellnessWeb" has been rated high by several search engines and with good reason. The site is designed to help patients find the best medical information and support, including news about clinical trials and treatment options. The site is an excellent source for professionals as well. Unique features include a women's health resource and the smoker's clinic, which is a collection of facts and stories about tobacco and smoking. Be sure to check out the "be happy be well" section of the site for great stress-busters. *http://wellweb.com*

Desktop travel agent: Before you take off on your next business trip or vacation, visit Excite's "city.net" for hints on entertainment and restaurants. The site even tells you the weather conditions, so you know how to pack for your trip. *http://city.net*

More software: "c/net" offers two sites for freeware and shareware downloads. *http://www.cnet.com*

Link to the arts: Carnegie Mellon University sponsors "ArtsNet" with links to theater, musical and fine arts events across the nation. A link to the "On Broadway" page leads you to schedules and reviews of broadway, off-broadway and cabaret shows. *http://artsnet.heinz.cmu.edu* IM

IMS staff members are on the watch for sites that might interest Iowa physicians. Staff members visit all Hot sites *to make sure they have useful information and reasonable download times. Suggestions for* Hot sites *can be sent to Melanie Finke by e-mail at communic@netins.net or by telephone at 800/747-3070.*

Throckmorton Surgical Society
Iowa Chapter - American College of Surgeons
Iowa Academy of Surgery

SPRING MEETING - May 2 - 3, 1997

Guest Faculty

Blake Cady, M.D.
Professor of Surgery
Harvard Medical School
Boston, Massachusetts

Richard E. Fine, M.D
The Breast Center
Marietta, Georgia

Armando E. Giuliano, M.D.
Clinical Professor of Surgery
UCLA Medical Center
Director, Joyce Eisenberg Keefer
Breast Center
John Wayne Cancer Institute of
St. John's Health Center
Santa Monica, California

Roger D. Gingrich, M.D.
Professor, Internal Medicine
The University of Iowa
Iowa City, Iowa

Donald W. Moorman, M.D.
Director, Surgery Education
Director, Surgical Division
Human Gene Therapy Research Institute
Iowa Health System
Des Moines, Iowa

Edgar D. Staren, M.D, Ph.D.
Associate Professor of Surgery
Rush Presbyterian-St. Luke's Medical Center
Chicago, Illinois

John Forsyth
President and CEO
Blue Cross & Blue Shield of Iowa

Thomas M. Foley, M.D.
Chairperson
Iowa State Committee on Trauma

Olga Jonasson, M.D.
Director of Education and
Surgical Services Department
American College of Surgeons

Samuel T. Wallace
President
Iowa Health System
Des Moines, Iowa

Topics

May 2, 1997

No need for axillary dissection - Modifications of traditional therapy as a result of declining size from mammographic screening - Locally advanced breast cancer - Stereotactic guided percutaneous biopsy - Comparison of stereotactic and ultrasound guided percutaneous breast biopsy - Bone marrow transplant - Sentinel lymphadenectomy staging of breast cancer - Technical aspects of sentinel lymphadenectomy - Genetics of breast cancer - Breast ultrasonography for the surgeon, by the surgeon: Physics, principles and instrumentation for normal breast ultrasound - Diagnostic and interventional breast ultrasound

May 3, 1997

Morning Session:
Health systems of the future - Partnering with physicians - Update of Iowa's trauma system - Education of a surgeon

Afternoon Session:
Presentation of surgery resident competition award papers - Presentation of papers by members of Iowa Academy of Surgery (topics TBA)

Accreditation

As an organization accredited for continuing medical education, the Iowa Methodist Medical Center certifies that this offering meets the criteria for Category I credit toward AMA Physicians' Recognition Award, provided it is used and completed as designed.

Friday, May 2, 1997:	7 hours
Saturday, May 3, 1997:	TBA

Cost

Physician fee.	$ 150.00
Resident fee.	$ 35.00

Contact:

Department of Surgery Education (515) 241-4076
Iowa Methodist Medical Center
1221 Pleasant Street, Suite 550
Des Moines, IA 50309

Meeting the challenges

Remember the day that you graduated from medical school, donned a white coat and took the Hippocratic Oath? For more than 2,000 years, physicians have taken this oath when they become doctors and begin practicing medicine. But for the last two years, medical students at the University of Iowa College of Medicine have taken the oath when beginning medical school as well as upon completion. We believe that the affirmations powerfully expressed in the Hippocratic Oath are as important for each entering medical student as they are four years later upon graduation.

Last year, only seven medical schools, including the UI, conducted the White Coat Ceremony. This year, the College's class of 2000 joined more than 50 medical colleges that held this "rite of entry". Incoming students, their families, as well as our faculty, had the opportunity to celebrate the commitment to caring as well as curing. Our new medical students recite the oath after being ceremonially cloaked with their first white coats — a symbol of the sanctity of the doctor-patient relationship.

During the ceremony, I reviewed the Oath with the students, almost line by line, to highlight its meaning and significance, and to point out that they will be entering a profession of high moral and ethical standards. One section particularly important to understand, especially at the early stage of the students' careers in medicine, reads, . . . *"That whatsoever I shall see or hear of the lives of others which is not fitting to be spoken, I will keep inviolably secret."* I emphasized that this trust is bestowed on our student doctors with the belief that it will help them provide patients with the best possible care and that the students will never violate the confidential nature of the information.

Our students have always been the focus of a great deal of our vitality. The new curriculum is providing them with more hands-on training and more computer resources, among other things. We greatly appreciate the efforts of many physicians around the state who are helping our students complete their community clerkships.

The new curriculum is providing them with more hands-on training and many more computer resources, among other things.

To provide the innovative teaching spaces necessary to teach our progressive new curriculum, a major capital planning project is under way which includes a new medical education and biomedical research building.

This year the University celebrates its 150 years of history. As we enter another period of change, we stand ready to meet the challenges of providing outstanding educational programs so that our students will have the appropriate knowledge and skills for the needs of society. IM



ROBERT KELCH, MD



Dr. Kelch, dean of the UI College of Medicine, is a pediatric endocrinologist.

IMS Update

News at a glance

Dr. Donald Young, a radiologist with the University of Iowa, is seeking re-election to the AMA Council on Scientific Affairs. Dr. Young has served one term on the Council. The election will be held during the AMA House of Delegates in Chicago June 22-26.

A catalog of smoking cessation resources for pregnant women entitled "Healthy Moms, Healthy Babies, Healthy Families" is available free at 1/800/322-1468.

Super hero at IMS House of Delegates!

Iowa physicians will gather April 18-20 for the Iowa Medical Society's 1997 Scientific Session and House of Delegates. The entire weekend of activity will take place at the Embassy Suites, Des Moines. In March, you should have received a program giving details of the Scientific Session program and registration information.



Since that mailing, IMS has been notified that the Extinguisher, the AMA's anti-smoking superhero, will appear at the Saturday House of Delegates and the Saturday evening banquet. The Extinguisher and his companion Dr. Know were created as part of the AMA's campaign against tobacco use by young people.

The Valley High School Singers will be the banquet entertainment.

Nancy Dickey, MD, chair of the AMA Board of Trustees, will be another special guest for the weekend's activities.

The first House of Delegates session will convene at 8:30 a.m. Saturday; the final session will be at 9:00 a.m. Sunday. Reference committees will begin at 1:00 p.m. Saturday.

Other events will include an IMPAC reception from 6:00–9:00 p.m. Friday evening and a risk management session sponsored by Midwest Medical Insurance Company on Saturday at 3:00 p.m.

As of press time, resolutions regarding licensure of utilization reviewers, telemedicine licensure, student representation in the House of Delegates and liability reform had been submitted for consideration by the House of Delegates. Copies of the resolutions will be found in a handbook mailed to delegates before the meeting or call Sandy Nelson at IMS headquarters.

News from Iowa Medical Group Management Association (IMGMA)

Don't kill the messenger

This is advice from Thomas Adams, MGMA executive vice president/CEO. In the February issue of *AM News* and *Medical Group Management Update* he reminds physicians to support, not fire, practice administrators for delivering the bad news. He says, (although the) "managed care/free market phenomenon (is putting) a grip on health care, (and) many physician practices are facing debt and declining income", the highly qualified practice administrator is your greatest ally.

Admittedly, there is very little an administrator or a physician can do to change the market. The administrator does, however, play a very significant role in the way the practice responds to the market. It is the role of the administrator to "learn and lead". The administrator can provide the business sense and knowledge needed to steer the practice through the tough times.

Physicians must team up with administrators. Physicians should have reasonable expectations of their practice administrator and administrators must also have reasonable expectations of physicians. The practice administrator is a "value-added asset" ready, willing and able to help ease the practice through changes we're living with today.

(This article was written by Denise Chaffee, IMGMA president and regional manager, Mercy Physician Services, Cedar Rapids.)

Candidate slate for 1997-98 officer elections

The Iowa Medical Society's annual elections will be Sunday, April 20 during the House of Delegates. The IMS Nominating Committee met on March 9 and approved the following candidate slate (length of term in parenthesis):

President-elect (1 year)	John Brinkman, MD
Vice president (1 year)	Jose Angel, MD
Trustee (3 years)	Hunter Fuerste, MD
House speaker (1 year)	Tom Throckmorton, MD
Vice speaker (1 year)	John Sutherland, MD

District Councilors (3-year terms)
District 3 — Eugene Kerns, MD
District 7 — Thomas Spragg, MD
District 8 — David Carlyle, MD
District 12 — William Kuyper, MD
District 15 — Kathryn Opheim, MD

AMA DELEGATION

AMA delegate (elect 2; 2-year terms)
Tom Graham, MD
Bryan Pechous, MD

AMA alternate (elect 2; 2-year terms)
Michael Disbro, MD
Janice Kirsch, MD IM

Specialty society update

The IMGMA Information and Communications Committee met and discussed a proposed newsletter publication policy. Cost for producing, printing and mailing the newsletter will increase due to the closing of the IMS print shop. The Education Committee met to solidify plans for the Spring Meeting at the Des Moines Marriott May 21-23 and to start plans for the Fall Meeting in Council Bluffs in October. The IMGMA Advisory Committee to the IMS EVP recently met. More meetings will be planned for the future.

The Legislative Committee of the Iowa Psychiatric Society meets every two weeks to review and discuss legislation in the Iowa General Assembly. The committee is particularly interested in legislation which would require a "point of service" option be provided to employees and a study bill which would define utilization review as the practice of medicine and require licensure in Iowa for physician reviewers employed by third party payers outside Iowa.

Iowa Association of County Medical Examiners Board met on Friday, February 21 at IMS headquarters. The annual education and business meeting will be held Friday, November 7 at Des Moines Golf & Country Club in West Des Moines. The tentative theme is death by motor vehicle.

The Iowa Academy of Otolaryngology Third Party Relations Committee will meet with a Blue Cross and Blue Shield representative to discuss diagnostic procedures on Wednesday, April 23 at 3:00 p.m. at IMS headquarters.

For more information, contact Dana Petrowsky or Dave Furneaux at 515/223-2816 or 800/728-5398.

A journey into cyberspace
1997 IMS Scientific Session

Focus on IMS Alliance

IMSA's legislative effort this year has been to promote the inclusion of non-violent wording on marriage licenses and certificates that reads: "The laws of this state affirm your right to enter into this marriage and at the same time to live within the marriage under the full protection of the laws of this state with regard to violence and abuse. Neither of you is the property of the other. Assault, sexual abuse and willful injury of a spouse or other family member are punishable by the laws of the State of Iowa."

West Virginia adopted this statement in 1992 and Kansas in 1993. We hope Iowa will be the third state to adopt this bill.

The IMS and IMSA support the adoption of this bill for a number of reasons:

- Domestic violence is a major public health problem in Iowa.
- Between January 1990 and 1995, 58 Iowa women and 8 Iowa men were murdered by a spouse or boy/girlfriend.
- From July 1994 through June 1995, 30,483 victims of domestic violence were served by programs receiving funding from Victim Services Grant Programs in Iowa.
- From June 1994 to July 1995, safe shelter was provided to 4,385 adults and 5,684 children who were victims of domestic violence in Iowa.

We encourage all IMS and IMSA members to contact their legislators and request their support for the adoption of this bill.

There's still time to register for "Journey into cyberspace", the IMS Scientific Session April 18, but please do it right away. Call Becky Bales at the IMS, 800/747-3070.

Legislative Affairs

News at a glance

Rep. Greg Ganske (R-IA) and Ed Markey (D-MA) have introduced the Patient Right to Know Act of 1997, anti-gag clause legislation which the AMA helped develop. The bill has over 120 bi-partisan sponsors.

The Virginia Senate has approved a bill authorizing the state attorney general to sue individuals for up to $100,000 if they assist in a suicide. If the bill becomes law, Virginia physicians could permanently lose their license to practice medicine if they participate in helping a patient end his or her life.

Liability cap dead

Friday, March 14 was the first funnel deadline when most bills must have been approved by a committee to be eligible for further consideration this year. Tax, spending and leadership bills are exempt from the deadline. Following is a summary of the status of key bills the IMS has worked on this year.

In last minute action, the House Judiciary Committee voted out a seriously weakened version of a tort reform bill, prior to the first legislative funnel deadline. The limit on noneconomic damages does not have enough support to be passed and is considered dead. In spite of assurances from legislative leaders that the IMS statute of limitations bill will be debated and voted on, at this point the bill contains none of the reforms requested by the IMS. Language strengthening the expert witness requirements in medical malpractice cases was also removed by the committee and is probably dead for the year. It is unclear how meaningful the remaining weakened provisions of the bill will be to other groups seeking reform of the tort system.

House leaders indicated their plan is that the statute of limitations issue can be amended to the bill in the Senate. It remains to be seen whether Senate rules will allow this to happen.

SF 153, a statute of limitations bill sponsored by Senator Maggie Tinsman (R-Davenport), was approved by the Human Resources Committee prior to the deadline, but it was referred to the Judiciary Committee for further consideration. As of this writing, Senate leadership has vowed that the bill will be approved by the committee, which will allow it to be debated.

While the lack of action on meaningful tort reform coming out of the House Judiciary Committee is disappointing, there is still a chance that the statute of limitations bill will be passed this year.

Point of Service Bill

The IMS/Iowans for Quality Health Care Coalition point of service bill has passed the House on a vote of 95-0. HF 133 requires large employers providing health benefits to offer employees at least one of three plans providing coverage for a patient's choice of physicians. Small employers who typically have more difficulty providing and administering health benefits must be offered these options but are not required to offer them to employees. Legislators view this bill as a reasonable compromise between the concerns of employers over health benefit costs and the concerns of patients and providers over ensuring that the full range of care is available to the employee/patient.

Utilization Review

SSB 156, the IMS bill that would require Iowa licensure of physicians who do utilization review of services provided to Iowa patients, died in committee. The IMS will continue to discuss ways to ensure adequate protections for patients whose access to care is affected by utilization review decisions.

Worker's Compensation

A bill has been approved by a Senate committee which would provide a mechanism for payment of health care providers when there is a benefit payment dispute between workers compensation and other health benefits. SF 296 would help physicians and hospitals col-

lect the sometimes substantial sums that are owed for services already provided.

Physician Liens

HF 152, by Grundberg, would allow liens to be filed for debts owed physicians for patient care services. Hospitals are already allowed to file such liens. It has been approved by the Judiciary Committee.

Certificate of Need

A bill increasing the dollar thresholds when a certificate of need is required is awaiting debate in the Senate. Current law requires a certificate of need for new services costing $300,000 or more or replacement services costing $400,000 or more. SF 236 would increase those thresholds to $1.5 million in most cases. Current law also contains a list of three services for which CON approval is always required for hospitals, regardless of cost: (1) cardiac catheterization service, (2) open heart surgical service and (3) organ transplantation service. SF 236 would add radiation therapy to that list and would require physician offices and clinics to receive CON approval for providing the four listed services. Current law exempts physician groups from that list.

This bill was initiated by the Association of Iowa Hospitals and Health Systems. The IMS has opposed the CON process since it began in the 1970s. The IMS supports raising the dollar thresholds, but opposes requiring physicians' offices to receive CON approval for the four listed services.

Abortion Reporting

SF 128, requiring physicians to report both elective and spontaneous terminations of pregnancy, has been passed by the Senate and is awaiting debate in the House. The IMS is neutral on the bill, but many physicians have questioned the need to report miscarriages. IMS has also worked to ensure that confidentiality protections are adequate for both patient and physician.

Tobacco

Several bills which would strengthen Iowa's tobacco laws have been introduced. SF 163 would eliminate the prohibition against local governments enacting tobacco regulations that are stricter than state law. SF 377 would increase penalties for possession, purchase or use of tobacco by underage individuals, including possible suspension of a driver's license. The IMS supports these bills.

Child Abuse

Many bills relating to child abuse are being discussed including redefining child abuse and expanding the assessment approach to dealing with child abuse investigations. The IMS opposes proposals to exempt certain types of injuries from the child abuse definition.

Domestic Violence

The IMS Alliance bill to require marriage licenses to contain a statement that domestic abuse is against the law has been approved by a committee and is awaiting House debate.

Adjournment of the legislative session is expected in early May. Many controversial issues, including income tax cuts, the death penalty and employee drug testing remain to be debated. IM

CONTACTING YOUR LEGISLATORS

Telephone numbers during the session:

Senators	**515/281-3371**
Representatives	**515/281-3221**
Governor	**515/281-5211**

Write to them at:
STATEHOUSE
Des Moines, Iowa 50319

You may also contact your legislators at home when the legislature is not in session. If you don't know who your legislator is or need your legislator's home address and phone number, call Cheryl Peers of the IMS staff, 800/747-3070 or 515/223-1401.

Medical Economics

News at a glance

Physicians at Tuscon's Thomas-Davis Medical Centers have voted 92-23 to join the Florida-based Federation of Physicians and Dentists. The National Labor Relations Board had previously certified that the medical staff physicians qualified as employees.

A federal appeals court has ruled that three New York anesthesiology groups can move forward with their antitrust case alleging that Aetna coerced them into signing unfair contracts. The contracts contained a termination without cause provision and allegedly prevented physicians from being advocates for patients being denied proper care. Physicians say they signed the contracts because Aetna threatened to pull its contracts from certain hospitals if they didn't.

OIG begins second round

The Office of the Inspector General has apparently sent another wave of surveys to physicians who order laboratory services. The survey asks specifically about blood indices.

Physician offices are advised that any contact from the OIG should be treated seriously. When the OIG sent the first round of surveys to Iowa physician offices, some offices did not realize the importance of the survey and did not respond appropriately.

IMS will keep you informed of developments in this area. If you have questions, call Barb Cannon at the IMS, 515/223-1401 or 800/747-3070.

Is Medicare the high payer?

Reports that Medicare is the high payer in comparison with private rates are incorrect, says a new report from the American Medical Association.

In fact, for a majority of cases, Medicare pays significantly less than the private sector, concludes the report.

A standard payment-based access indicator for physician services is the national average ratio of Medicare to private sector physician fees. Estimates of the national average gap between Medicare and private rates have ranged from 59% to 76% for the period from 1990 to 1994.

The Physician Payment Review Commission estimates that Medicare paid 70% of what the average private insurer paid in 1995.

Given variation in market competition, payments and service utilization across payers and regions, local area measures of the gap between Medicare and private sector fees may be more meaningful than national average benchmarks of the payment gap.

According to the study, Medicare payments were found to be lower than the private sector price in 92% of cases. Therefore, instances in which Medicare pays more than private payers appear to be isolated occurrences or based on questionable data, concludes the AMA.

For the study, the AMA examined local area differentials between Medicare and private sector physician payments based on a dataset with over 19,000 observations.

Billing compliance plans

Much attention is being focused on billing compliance programs, and a recent Federal Register included a model compliance program.

IMS members and their office staff will be able to get practical assistance this summer in 11 cities across the state. A series of workshops is being scheduled on "The ABCs of Compliance Programs". Watch future issues of *Iowa Medicine* for more details. IM

IMPORTANT MESSAGE

FOR IMS Members and their office staff

DATE Today! TIME NOW

FROM IMS Practice Management Dept.

PHONE (800) 728-5398

TELEPHONED		PLEASE CALL	
WANTS TO SEE YOU	✓	WILL CALL AGAIN	
RETURNED YOUR CALL		IMPORTANT	✓

MESSAGE Don't miss the third annual IMS Specialty Coding Extravaganza, April 29, 30 and May 1 featuring ob/gyn, surgery, oncology, E&M and CCI (see details on Practice Management page).

DATA & TECHNOLOGY

Medicare cuts based on how you practice medicine

President Clinton recently unveiled his budget for FY 1998, including his plan to trim Medicare spending. The president proposes to cut $100 billion as part of his five-year balanced budget plan. Most physicians have read how the cuts will affect their Medicare reimbursement through "single conversion factors" and "sustainable growth rates."

There is another part of this plan that may not be as well known. According to an article in *Medicine and Health Perspectives*, a newsletter published by Faulkner & Gray, some of the cuts will be based upon how a physician practices medicine.

The article states, "Effective January 1, 2000, the proposal would limit payments to groups of physicians practicing in hospitals whose volume and intensity of services per admission exceed 125% of the national median for urban hospitals and 140% for rural hospitals. For each doctor practicing in hospitals above those limits, 15% of each payment would be withheld during the year. If doctors worked together more efficiently, they'd get the withheld payments plus interest at the end of the year." Presumably, if doctors don't become more efficient they lose the 15% withhold.

How do you find out if your volumes and use of hospital resources are within the percentage thresholds? IMS can help answer this question.

IMS is in partnership with QuadraMed Corporation for the exclusive use of its QuanTIM Performance Measurement software. This software will analyze a physician's use of hospital resources compared to other physicians within the hospital, within a geographic area or statewide. Specific comparisons are made on number of admissions, length of stay and total charges, key indicators of resource consumption.

In addition, the software will compare rates of outcomes, such as surgical complications, surgical infections, c-sections, mortality, etc., using both overall averages and risk adjusted rates. The article did not state if Medicare will adjust the data in case a physician treats more acutely ill patients, but risk adjustment is absolutely essential if payments are to be based on this system. Risk adjustment is a technique that is used to take into account, or control for, the fact that different patients with the same diagnosis may have pertinent, risk-increasing conditions or characteristics that impact the probability of having a particular outcome.

A myriad of other reporting options are available with the software. Physicians can even review patient level detail to determine the accuracy of the data. Reports are available for purchase through the IMS at the member rate of $250.

Obviously, there will be much debate about Medicare cuts in order to keep the program solvent and balance the entire federal budget. If this proposal remains in the plan, the government often uses data from prior years to establish a baseline. The baseline could be obtained from 1994, 1995 or 1996 data, all of which is or will soon be available in the IMS data base.

Physicians would be wise to determine how they would fare under this proposal while there is time to plan. This proposal is a scary proposition. Not only is it unfair, but as Medicare goes, so goes much of the payer industry. IM

Same-day mastectomy procedures were a topic in the 1997 Iowa Legislature. The Iowa CHMIS provided data on the trend toward shorter hospital stays for mastectomies, data which showed one Iowa community having significantly higher one-day stays.

For more information, call Ed Whitver, director, department of administration, 515/223-1401 or 800/747-3070.

Practice Management

News at a glance

IMS staff has discovered an error in the February issue of CPT Assistant. *A question which stated "Is a 25 modifier ever warranted with 99211?" actually referred to a 21 modifier.*

A new clinical practice guideline, Recognition and Early Assessment of Alzheimer's Disease and Related Dementias *helps clinicians identify changes in patients which might be symptoms of Alzheimer's and other dementias. Copies of the guideline can be purchased from the Government Printing Office at 202/512-1800. To access the guideline on the Internet, go to http://www.ahcpr.gov/guide/.*

Coding questions on IMS web site

Do you have a question about coding, or another practice management issue? Check out the IMS web site on the World Wide Web.

A standing feature of the IMS home page is "Practice Management Question of the Week". Following are examples of questions generated which appear on the web site.

Q. Is it okay to choose an E & M service code based on the time the physician spends with the patient?

A. Yes, and it's a good idea to consider "time" when choosing an E & M service code. In the office, "time" is defined as face-to-face time between the patient and the physician (not time spent with a nurse, dietary educator, etc.). In the hospital, "time" includes time spent at the bedside with the patient; time spent with the family; time revising diagnostic and consultant reports, data and notes from others on the care team.

Record documentation needs to state total time spent on the service and show that 50% or more of the time was spent counseling the patient or coordinating patient care. Be sure to specify what "care" you are documenting.

For more guidance on using time, see the definition of "time" at the beginning of the E & M section of the 1997 CPT code book.

Q. Why would you bill code 99024 for post-operative follow-up visits? I thought these were included in the global package.

A. Many surgical services include a post-operative follow-up period known as the global period (usually 10, 14 or 90 days). During that time, no post-operative services related to the surgery can be billed since they are included in the package.

However, code 99024 can be billed with no charge as a way of tracking the number of post-operative visits associated with a particular surgery. With the increasing importance of outcome measures and efficiency studies, it may be useful to track the number of post-operative visits associated with certain diagnoses or certain physician practices. Make sure there is no charge for code 99024 if you submit it to a third party payer. IM

http://www.IowaMedical Society.org

Practice Management Workshops for You

Specialty Coding Extravaganza III

April 29-30, May 1 — **Best Western Airport Inn, Des Moines**

Oncology, cardiology, obstetrics and gynecology, E&M documentation guidelines, audit score sheets and Medicare's correct coding initiative. Instructors: Jennifer Jones, Nancy Maguire, Barb Cannon.

Resource Management

June 5 — **IMS Headquarters West Des Moines**

Accounting, tax and human resource information. Instructors from Vroman, McGowen, Hurst, Clark & Smith, P.C.

For more information or to register for any IMS practice management workshop, call Sherry Johnson at IMS Services, 515/223-2816 or 800/728-5398.

Midwest Medical Insurance Company Focus on Risk Management

Case study: preventing medication errors

A patient was examined after injuring her foot. An x-ray ruled out a fracture and the patient was advised by her physician to take one Advil three times a day as needed. The patient developed swelling of her face and neck with blistering following the ingestion of one tablet and was examined at an urgent care center. In review of her medical record, the patient did have a well-documented history of allergic reactions to Naprosyn. The physician later testified that he had failed to review her record before prescribing the over-the-counter medication.

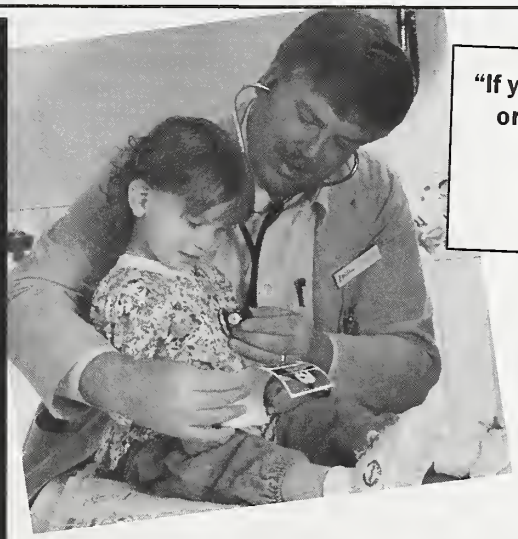
In another case, a patient was given a prescription for Inflamase eyedrops to be instilled p.r.n. The physician instructed the patient to discontinue the eyedrops after one week's use. These instructions were documented on the chart, but the prescription was refilled by the clinic staff several times over a one-year period. The patient denied being instructed to discontinue the drops and developed steroid-induced glaucoma in one eye as a result.

While the injuries in these two cases seem to be minor, a study by the Physician Insurers Association of America reveals that medication errors can cause significant patient injuries. In fact, 42% of the injuries from medication errors in this study resulted in serious permanent injury or death as was the case in the following malpractice claim.

A 28-year-old patient was diagnosed with testicular cancer. Following surgery, he was referred from the tertiary center to his hometown where chemotherapy was to be continued. He was admitted to the hospital for his third round of Bleomycin. A chest x-ray was read as abnormal by the radiologist, but his physician had already administered the Bleomycin before reading the report. A few days after discharge from the hospital, he returned to the clinic complaining of shortness of breath, a dry cough and chest discomfort. He was admitted to the hospital with adult respiratory distress syndrome and eventually died of complications related to Bleomycin toxicity.

All these patient injuries could have been prevented by review of the patient's record. Complete documentation and thorough review by all health care professionals involved in the prescribing, refilling or administering of medications can prevent patient injuries and malpractice claims.

For more information contact Lori Atkinson, MMIC risk management supervisor, Midwest Medical Insurance Company, West Des Moines Office, PO Box 65790, West Des Moines, Iowa 50265; 800/798-9870 or 515/223-1482.



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– Bill Geserick, M.D.

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Newsmakers

News at a glance

Dr. Nancy Dickey, chair of the American Medical Association Board of Trustees, will be a special weekend guest at the IMS Annual Meeting, April 19 and 20 at the Embassy Suites Hotel, Des Moines.

The IMS and Midwest Medical Insurance Company (MMIC), the IMS-affiliated liability insurer, are working together to establish the Physician Litigation Support Program and are looking for volunteer physicians who will offer assistance, information and emotional support to colleagues who are being sued. For more information or to volunteer, call Lori Atkinson at 800-798-9870.

Gold Seal Award for Iowa Medical Society

Dear Editor:

On behalf of the Iowa Coalition Against Domestic Violence, it is my privilege to notify you that the Iowa Medical Society has been nominated and selected by the Iowa Coalition Against Domestic Violence Board of Directors to receive a Gold Seal Award for its excellent state level initiatives on behalf of battered women and their children. We are appreciative and indebted to you.

Congratulations and thank you for the work that you do.—*Laurie Schipper, executive director, Iowa Coalition Against Domestic Violence, Des Moines*

Letter to the Editor

UI College of Medicine news

Dr. Richard Brand, professor of orthopaedic surgery, has been named president-elect of the Orthopaedic Research Society. **Dr. Claibourne Dungy**, professor of pediatrics and director of the Division of General Pediatrics, has been elected to a three-year term on the board of directors of the Ambulatory Pediatric Association. **Dr. Alfredo Fabrega**, assistant professor of surgery, has been named the American Society of Transplant Physicians-ROCHE New Investigator for 1996. **Dr. Kristi Ferguson** has been appointed director of the Office of Consultation and Research in Medical Education after serving as interim director. **Dr. Jeffrey Galvin**, professor of radiology, has been selected as a Distinguished Scientist for Radiologic Pathology at the Armed Forces Institute of Pathology for 1997-98. **Dr. David Lubaroff**, professor or urology, has been elected vice president and president-elect of the Society for Basic Urologic Research. **Dr. William Mathers**, associate professor ophthalmology, received a five-year, $1.2 million grant from the National Eye Institute of the National Institutes of Health to study how dry eye affects men and women differently. **Dr. Amanda Metcalf**, professor of surgery, has been named Iowa state chair of the American College of Surgeons Cancer Liaison Program. **Dr. Kim Overby**, assistant professor of pediatrics, has been appointed assistant dean for student affairs and curriculum. **Dr. Robert Robinson**, professor and head of psychiatry, has been named Paul W. Penningroth Professor of Psychiatry. **Dr. Richard Williams**, professor and head of urology and deputy director of the UI Cancer Center, is the principal investigator on a project that received a $92,500 institutional grant from the American Cancer Society. **Dr. Jay Sandlow**, assistant professor of urology, received a $15,000 American Cancer Society seed grant award from the UI Cancer Center for his research on growth factors associated with testicular cancer. **Dr. Eric Devor**, assistant professor of psychiatry, has been named assistant editor of *Psychiatric Genetics*.

Deceased members

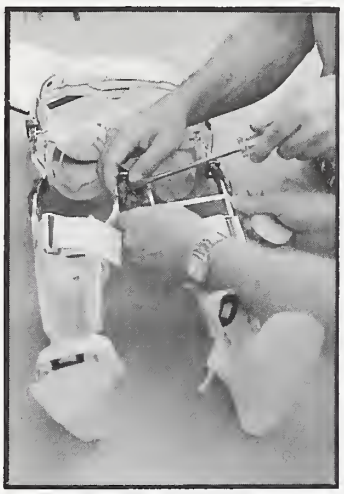
Lester Kimberly, MD, 85, life member, dermatology, Davenport, died December 9

Paul Crowley, MD, 80, family practice, Bettendorf, died January 30

Earl Bickel, MD, 68, orthopedic surgery, Cedar Rapids, died January 21 IM

What's Important Here?







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Telemedicine's role in UI statewide service

Rapid innovation in telecommunications technology means big changes for many professions, medicine included. Telemedicine — defined as the electronic transmission of medical information and services from one place to another — is widely heralded, but questions of how and when it should be used remain.



C. LINDON LARSON
Mr. Larson is an associate editor for Health Science Relations at the University of Iowa.

Created in 1994 with a $7.3 million contract from the National Library of Medicine (NLM), the National Laboratory for the Study of Rural Telemedicine at the University of Iowa College of Medicine leads an effort to assess the potential of telemedicine in Iowa and beyond.

Model program

"I think most people in the field would consider ours a model program because of the way it is constructed and the diversity of applications we are working on," says Dr. Michael Kienzle, associate dean for clinical affairs and director of the UI telemedicine program.

Its national reputation was confirmed last fall when the program received a second NLM contract with up to $6.2 million for research projects that explore the direct impact of telemedicine on patient care.

Ten Iowa hospitals are linked to the UI telemedicine network, many in communities with limited access to specialized medical services. While early projects offered information resources and medical imaging support to affiliated hospitals, several new initiatives will explore teleconsultations with physicians and patients at distant sites.

Dr. James Torner, professor of preventive medicine and environmental health, studies ways to improve rural emergency care with efficient and reliable communication between networked hospitals and the UIHC. He has developed a relatively inexpensive desktop system that allows physicians to share images, data and patient records.

> **The hope is that high technology can improve patient care while continuing a tradition of partnership with Iowa physicians and communities.**

"With video conferencing, physicians at the UI and in the community can look at information simultaneously. They can determine whether a patient should be treated and transferred," he says. Originally intended for consultations in trauma cases, the system also will be used to eval-

uate and treat patients with vascular ischemia.

Observe and advise colleagues

Once the system is in place, physicians treating suspected myocardial or brain ischemia at rural hospitals can dial up the UIHC to consult with colleagues on whether to administer thrombolytic therapy. Full-motion video will allow UI specialists to observe the examination and advise local providers on treatment. A specialized database will provide diagnostic information and help facilitate communication between sites.

Torner hopes the system will improve outcomes and reduce costs by eliminating unnecessary patient transfers. The trauma support project recently began service to participating sites and vascular ischemia assessment will follow this fall.

Other investigators are studying how telemedicine can provide direct clinical services to remote sites. Communicating via video may ease time and travel demands on both patients and physicians.

Mental health care for underserved areas

Dr. Barbara Rohland, assistant professor of psychiatry, hopes that telemedicine can provide mental health care to underserved areas. She will study whether treatment and management for serious conditions like schizophrenia, bipolar disorder and major depression can be successfully delivered using a video link between the UI and participating hospitals.

Building professional relationships with local mental health providers is another goal. "Telepsychiatry should be seen as service that will support rather than replace local mental health care providers," Rohland says. "We want to work with providers so that access to psychiatric services will be increased without interrupting the continuity of existing care."



Teams of UI physicians evaluate patients through video conferencing.

Repeat use will be one measure of satisfaction for both patients and local providers. The project will be carried out in two communities where Rohland already operates outreach clinics, allowing for comparison between standard visits and long-distance care.

Teleconferences could replace UI visits

Telemedicine has potential to deliver a variety of services in concert with local providers. Dr. James Hardy of the University Hospital School studies how such technology can help assess the needs of children with disabilities. Interdisciplinary teams at the Hospital School will join local health professionals, children and parents in teleconfer-

Ten Iowa hospitals are linked to the UI telemedicine network, many in communities with limited access to specialized medical services.

ences designed to replace visits to the UI.

Cost comparisons will help researchers judge the success of the project, as will surveys of parent and provider satisfaction. Hardy hopes it will foster improved communication between health professionals.

"This gives us the opportunity to interact directly with local service providers. We can answer their questions on the spot and can structure our recommendations with their input," he says.

Originally intended for consultations in trauma cases, the system also will be used to evaluate and treat patients with vascular ischemia.

Telemedicine may become the latest aspect of the UI's role as health service provider for the entire state. In addition to their work with community hospitals and clinics, telemedicine researchers have teamed with the Iowa Department of Corrections to evaluate teleconsultations at the state's correctional facilities.

Since its inception, the telemedicine program has focused on supplementing local services to meet recognized needs. One ongoing project brings advanced physiologic imaging techniques to small hospitals, facilitating consultations with UI specialists while teaching local physicians to perform their own image analysis. Another seeks the most effective ways to offer radiology support for hospitals that lack full-time radiologists.

Telemedicine and networked hospitals

By providing links to the UI Virtual Hospital and databases at the Hardin Library for the Health Sciences, telemedicine also delivers a wealth of medical information to networked hospitals. A new project will develop additional interactive resources, including large video databases that providers and patients can access on demand.

Also funded by the latest NLM contract is a project to deliver on-line health information directly into the homes of people living with diabetes. "This is a new direction for us," Kienzle says. "It parallels the direction that many people in health care telecommunications see things going — more information directed into the home."

Whether focusing on hospitals or homes, telemedicine research aims to guide the UI's mission of statewide service into the information age. The hope is that high technology can improve patient care while continuing a tradition of partnership with Iowa physicians and communities. IM

World Wide Web Sites for Health Resources

Staff at the University of Iowa Virtual Hospital (http://indy.radiology.uiowa.edu) suggest the following World Wide Web sites to physicians looking for useful on-line health resources:

The American Medical Association
http://www.ama-assn.org

Medicine on the Net
http://www.medicinenet.com

Medscape
http://medscape.com

OncoLink
http://www.oncolink.upenn.edu

The Parents Place
http://www.parentsplace.com

Thrive
http://pathfinder.com/thrive

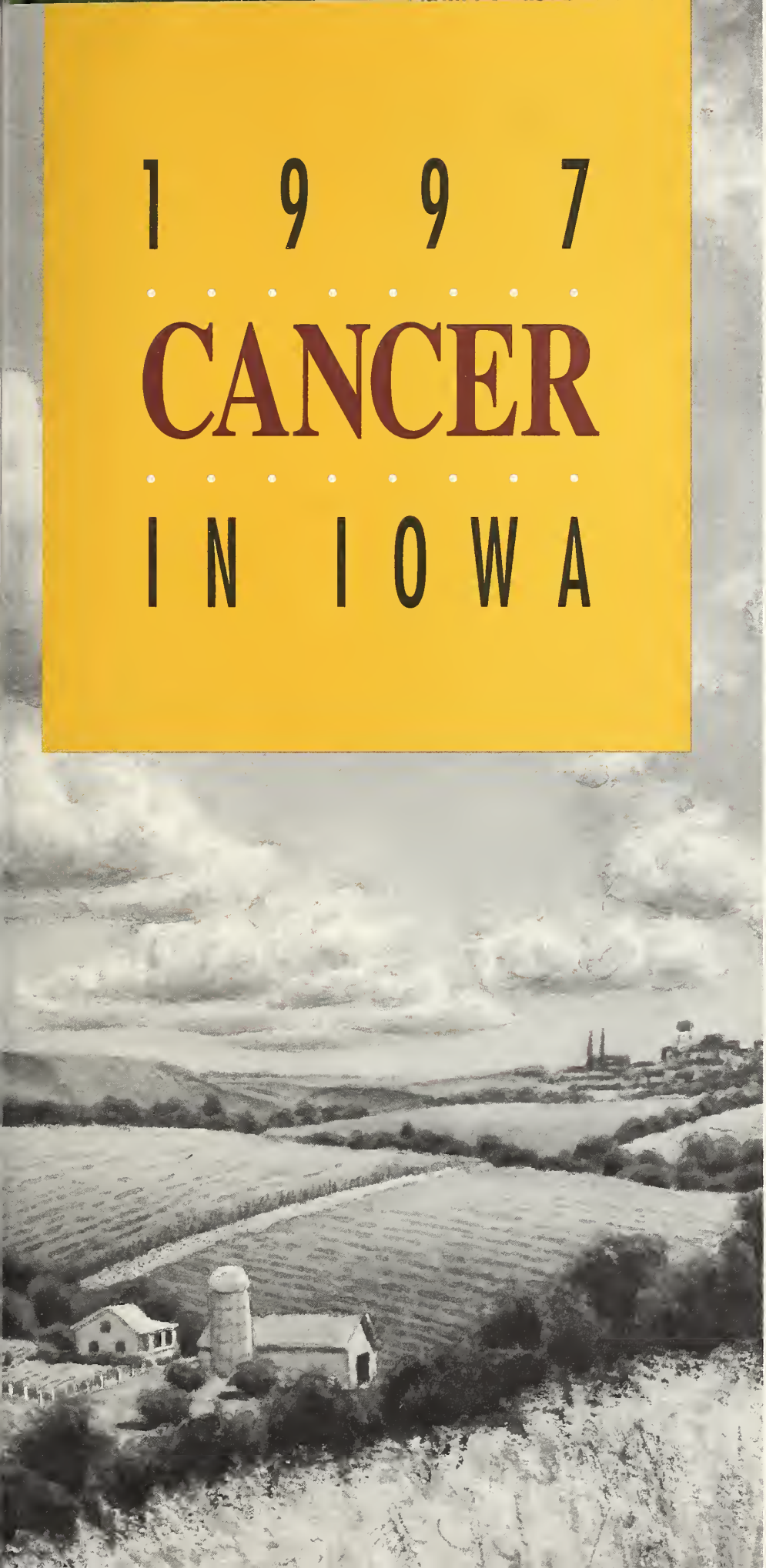
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The New England Journal of Medicine
http://www.nejm.org

PharmInfoNet
http://www.pharminfo.com

The Doctor's Guide to the Internet
http://www.pslgroup.com/docguide.htm

1997 CANCER IN IOWA



FACTS ABOUT **CANCER** IN IOWA

R ates of survival are increasing for many cancer sites in Iowa

E stimates predict 2,050 cases of breast cancer will be diagnosed in 1997

S moking is the number one risk factor for lung cancer

O ver 2,000 prostate cancers will be diagnosed in 1997

L ung cancer is the leading cause of cancer death in males and females

V alue your health — see your physician regularly

E ducation is the key for early detection of disease

In 1997, an estimated 6,300 Iowans will die from cancer, 12 times the number caused by auto fatalities. Cancer is second only to heart disease as a cause of death. These projections are based upon data from the State Health Registry of Iowa. The Registry has been recording the occurrence of cancer in Iowa since 1973, and is one of ten registries nationwide providing data to the National Cancer Institute.

Produced by

STATE HEALTH REGISTRY OF IOWA

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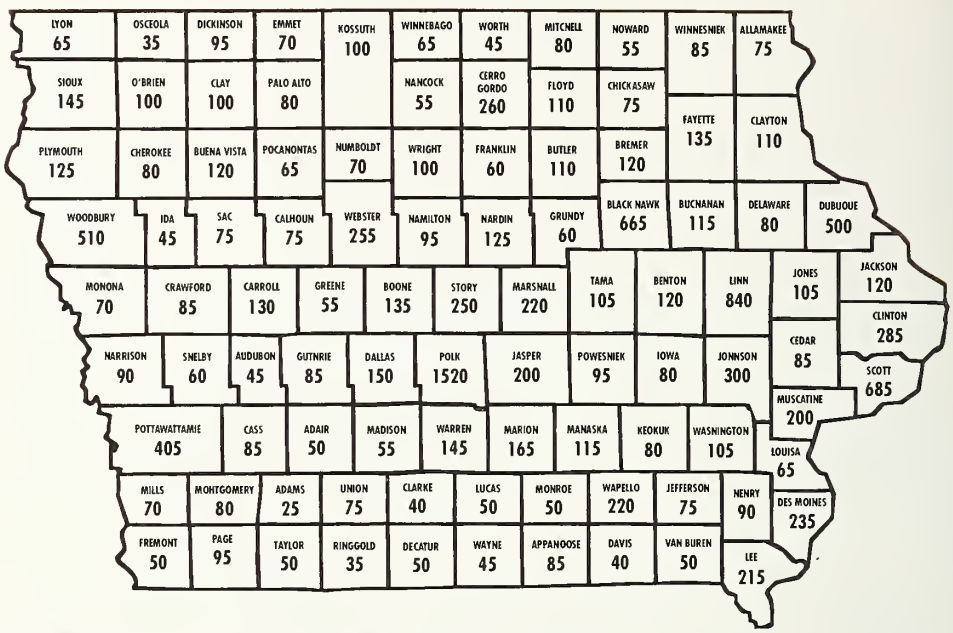
Cancer is a reportable disease as stated in the Iowa Administrative Code. Cancer data are collected by the State Health Registry of Iowa, located at The University of Iowa in the College of Medicine's Department of Preventive Medicine and Environmental Health. The staff includes more than 50 people. Half of them, situated throughout the state, regularly visit hospitals, clinics, and medical laboratories in Iowa and neighboring states to collect cancer data. In 1997, data will be collected on an estimated 14,500 new cancers among Iowa residents. A follow-up program tracks more than 97 percent of the 280,000 Iowans diagnosed with cancer since 1973. This program provides regular updates for follow-up and survival. The Registry maintains the confidentiality of the patients, physicians, and hospitals providing data.

This excerpt provides information from the State Health Registry's annual publication *1997 Cancer in Iowa*.

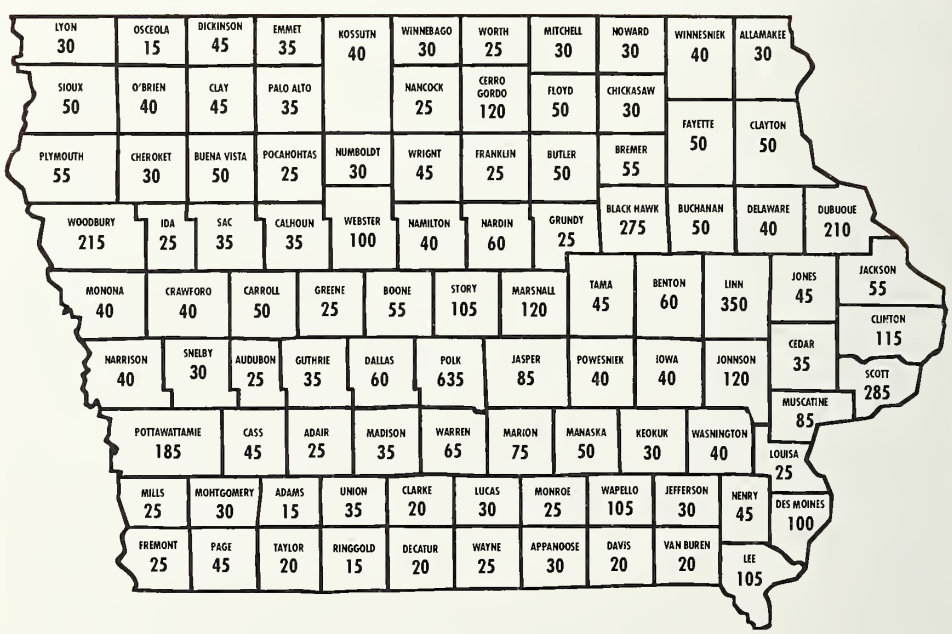
CANCER PROJECTIONS FOR 1997

Cancer affects Iowans of all ages and in every county. In 1997, cancer will strike five out of every 1,000 and cause death to two of every 1,000.

ESTIMATED NUMBER OF NEW CANCERS IN IOWA FOR 1997



ESTIMATED NUMBER OF CANCER DEATHS IN IOWA FOR 1997



TOP 10 TYPES OF CANCER IN IOWA ESTIMATED FOR 1997

Breast cancer is the most common female cancer. Cancers of the breast, colon, rectum, and lung will account for more than half of all new cancers. Lung cancer is the most common cause of cancer death in females followed by breast cancer.

Cancer occurs in people of all ages, although more than 80 percent of all new cancers are diagnosed in those 55 years of age and older.

Prostate, lung, colon, and rectum cancers account for almost 60 percent of all new cancers in males. Lung cancer causes almost one-third of all male cancer deaths.

New Cancers in Females

TYPE	# OF CANCERS	% OF TOTAL
BREAST	2050	29.3
COLON & RECTUM	1050	15.0
LUNG	850	12.1
UTERUS	450	6.4
NON-HODGKIN'S LYMPHOMA	300	4.3
OVARY	280	4.0
SKIN MELANOMA	200	2.9
LEUKEMIA	190	2.7
PANCREAS	170	2.4
KIDNEY & RENAL PELVIS	160	2.3
ALL OTHERS	1300	18.6
TOTAL	7000	

Cancer Deaths in Females

TYPE	# OF CANCERS	% OF TOTAL
LUNG	680	22.3
BREAST	470	15.4
COLON & RECTUM	400	13.1
PANCREAS	170	5.6
NON-HODGKIN'S LYMPHOMA	150	4.9
OVARY	150	4.9
LEUKEMIA	130	4.2
UTERUS	90	3.0
BRAIN	70	2.3
KIDNEY & RENAL PELVIS	70	2.3
ALL OTHERS	670	22.0
TOTAL	3050	

New Cancers in Males

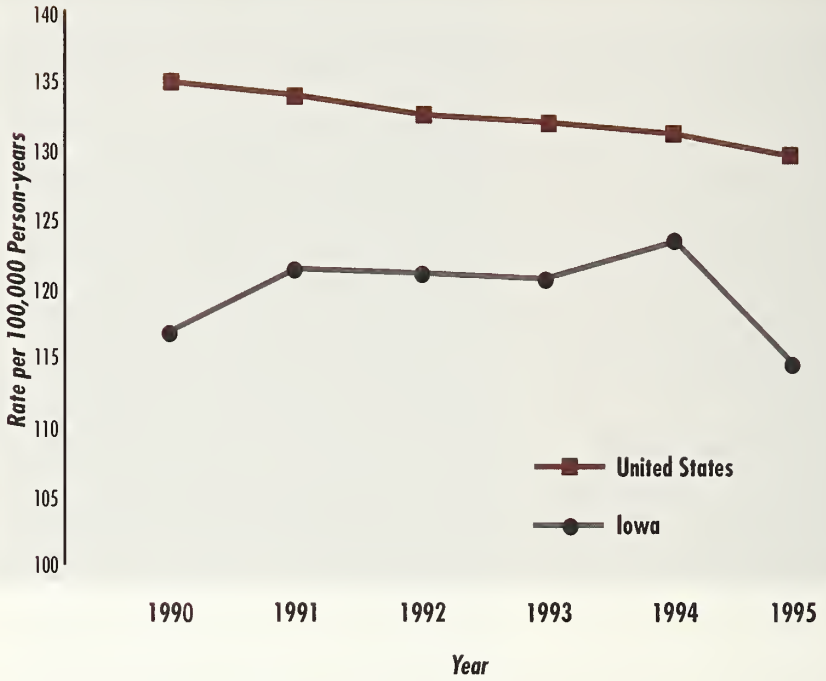
TYPE	# OF CANCERS	% OF TOTAL
PROSTATE	2200	29.4
LUNG	1300	17.3
COLON & RECTUM	950	12.7
NON-HODGKIN'S LYMPHOMA	290	3.9
BLADDER	250	3.3
LEUKEMIA	240	3.2
SKIN MELANOMA	220	2.9
KIDNEY & RENAL PELVIS	210	2.8
ORAL CAVITY	180	2.4
PANCREAS	150	2.0
ALL OTHERS	1510	20.1
TOTAL	7500	

Cancer Deaths in Males

TYPE	# OF CANCERS	% OF TOTAL
LUNG	1050	32.3
PROSTATE	430	13.2
COLON & RECTUM	340	10.5
LEUKEMIA	150	4.6
NON-HODGKIN'S LYMPHOMA	150	4.6
PANCREAS	140	4.3
BLADDER	90	2.8
BRAIN	90	2.8
ESOPHAGUS	90	2.8
KIDNEY & RENAL PELVIS	80	2.4
ALL OTHERS	640	19.7
TOTAL	3250	

AGE-ADJUSTED CANCER MORTALITY RATES*, 1990-1995

The United States' age-adjusted cancer mortality rates have steadily decreased 4% from 1990 to 1995 while Iowa's rates have not. Iowa's rates, however, have been consistently below the United States' rates.



*Rates adjusted to the 1940 U.S. population

Fortunately for Iowans, the chances of being diagnosed with many types of cancer can be reduced through positive health practices such as smoking cessation and healthful dietary habits. Early detection through self-examination and regular health check-ups can dramatically improve cancer survival.

TOP 10 CAUSES OF DEATH IN IOWA FOR 1995

Cancer remains the second most common cause of death behind heart disease.

CAUSE OF DEATH	NUMBER OF DEATHS	% OF ALL DEATHS
HEART DISEASE	9334	33.6
CANCER	6235	22.5
CEREBROVASCULAR DISEASE	2207	8.0
CHRONIC LUNG DISEASE	1361	4.9
PNEUMONIA	1178	4.2
ACCIDENTS	1115	4.0
DIABETES	644	2.3
ARTERIOSCLEROSIS	417	1.5
INFECTIONS	400	1.4
OTHER ARTERIAL DISEASES	370	1.3
ALL OTHER CAUSES	4522	16.3

The science behind the medicine . . .

Lay people go to medical school

Medical faculty and members of the community enjoyed a six-week course on biomedical research and medicine. This successful mini-med school was designed to teach lay people more about the latest clinical advances as well as give them a glimpse at the hard science behind medicine.

They could have been home catching up on household chores, relaxing or watching television. Instead, more than 150 people spent six Tuesday evenings sitting in a classroom, learning about the science behind medicine and the latest in medical treatments.

Program geared toward a lay audience

But these weren't college students required to attend class. They were members of the community who were participants in the UI College of Medicine's first Mini-Medical School, designed to familiarize the lay public with biomedical research and medicine.

"The Mini-Medical School features some of our best teachers who present the material in a way that is interesting and understandable to a lay audience," says Dr. Allyn Mark, associate dean for research development and graduate programs and director of the Mini-Medical School. "The course gives people a chance to learn more about the latest in clinical advances in medicine, but also gives them a glimpse at the hard science behind medicine," he explains.

The program covered a wide variety of clinical and basic science topics, including the sessions "Pain Made Plain"; "Making Sense out of Sensibility: Where the Brain Ends and the Mind Begins" and "Genetic Engineering: Modern Medicine or Messing with Mother Nature".

Not your usual classroom lecture

Rather than just scientific lectures, most presentations were entertaining as well. Presenters used real patient cases, colorful analogies and humor to make complex information understandable. Participants were even serenaded during the second session by Dr. Peter Rubenstein, professor of biochemistry, who sang a song he sings each year to new medical students.

> It made me a better citizen because I'm now better informed about some of the diseases and conditions that can affect my fellow man.

Medical faculty, whose schedules are



Vera Dordick
Ms. Dordick is assistant director of Health Science Relations at the UI College of Medicine.

crammed with patient care, research and teaching responsibilities, were eager to participate in the program.

"It's important because it helps the public become more aware of the kinds of research being conducted at Iowa and helps highlight the rapid pace of biomedical research and how fast things are changing with regard to our understanding of diseases and their treatments," says Thomas Schmidt, associate professor of physiology and biophysics, whose presentation focused on basic physiology and the endocrine system.

Presenters used real patient cases, colorful analogies and humor to make complex information understandable.

Dr. Gerard Clancy, assistant professor of psychiatry, who spoke on mental illness and schizophrenia, agrees. "It is a great opportunity to be able to explain some of the mysterious sides of medicine, particularly mental illness, to a lay audience," he says.

Mini-Medical School faculty were also impressed by the students' willingness to learn. "I enjoyed the audience participation and the insightful questions. I was very impressed that so many of the participants could follow what I was saying and asked relevant and interesting questions," Schmidt says.

Participants respond positively to program

Because curiosity is the only requirement for attending, students come to classes for a variety of reasons. For the youngest participants, 14-year-old Olabode and 11-year-old Ololade Olakanmi, it was their intent to pursue a career in medicine that led them to the mini-med school.

"I have decided that I would like to be a neurosurgeon and my brother a transplant surgeon," says the elder Olakanmi. "Our dad is a biochemist, and living in a family where somebody works in science, you get to know a lot about it."

Others, like Sandy Delay of Cedar Rapids, enrolled in the program to get a more up-to-date view of medicine. Delay, whose husband has had four cardiac bypasses, found the clinical medicine session most interesting because it focused on the heart.

Alan Weinstein of Iowa City enjoyed the scope and range of the topics covered. "It has also made me more humanly wise in a couple of areas. It made me a better citizen because I'm now better informed about some of the diseases and conditions that can affect my fellow man," says Weinstein, who attended the sessions with his 13-year-old son.

Mini-med school attendees also turned out to be a dedicated group: Tim Murphy, who owns an Iowa City lawn care company, took time away from his wedding anniversary celebration to attend a session. Another participant who was hospitalized at UI Hospitals and Clinics during the third week of the Mini-Medical School attended that week's session with her IV pole in tow.

With this initial run of the mini-med school, the UI joins about two dozen academic health centers around the country who have similar programs. All spots in the UI Mini-Medical School were filled the first week after the program was announced. IM

Win–Win–Win!

PERSONAL FINANCIAL STRATEGIES

If you're like everyone else, you hate to pay taxes. It's that universal aversion that causes many people to hold on to an appreciated asset in order to avoid capital gains tax. They are held captive by the very success of their planning and investment decisions.

What would you say if you could utilize a planning strategy that would allow you to increase income from your assets, receive an immediate substantial tax deduction, build retirement funds for the future and increase the estate you leave your heirs. No doubt, your interest would be piqued.

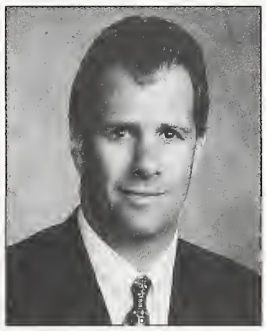
The planning strategy that can accomplish all of this is a charitable remainder trust. Here's how it works: you take a highly appreciated asset and gift it to a charitable remainder trust before the asset is sold. Since it is gifted to a charitable trust, there is no capital gains tax on the gift and an immediate tax deduction is available for making the gift. The asset is then sold by the trust, thus avoiding tax on the gain as well. The money can then be invested as desired by the trustee and will create an income stream for as long as the income beneficiaries live. The creator of the trust can name himself or herself, his or her spouse and anyone else they wish as income beneficiaries. The remainder beneficiary receives all the assets that remain in the trust after the last income beneficiary dies. This beneficiary must qualify as a non-profit organization.

The down side of this strategy is that the heirs are the ones who lose out on receiving the asset at death. If this is an issue, then another strategy can be implemented utilizing an irrevocable life insurance trust. With the increased income from the trust, a life insurance policy can be purchased by a trust on the life of the donor, naming the heirs as the beneficiaries, thus replacing the assets that will ultimately go to charity.

In addition to the obvious tax and income benefits, you also get to enjoy the additional value of diversifying your portfolio. Non-financial benefits which should be considered include the immediate recognition as the result of making a significant gift and the opportunity of creating a legacy that will last beyond your life. It's difficult to put a monetary value on this.

Non-financial benefits include the immediate recognition as the result of making a significant gift and the opportunity of creating a legacy that will last beyond your life.

As you can see, utilizing a charitable remainder trust can be a win-win-win strategy. IM



JERRY FOSTER

Jerry Foster is the founder and president of Foster Capital Management, a fee-based financial advisory firm endorsed by the Iowa Medical Society. Mr. Foster can be reached at 1-800/798-1012.

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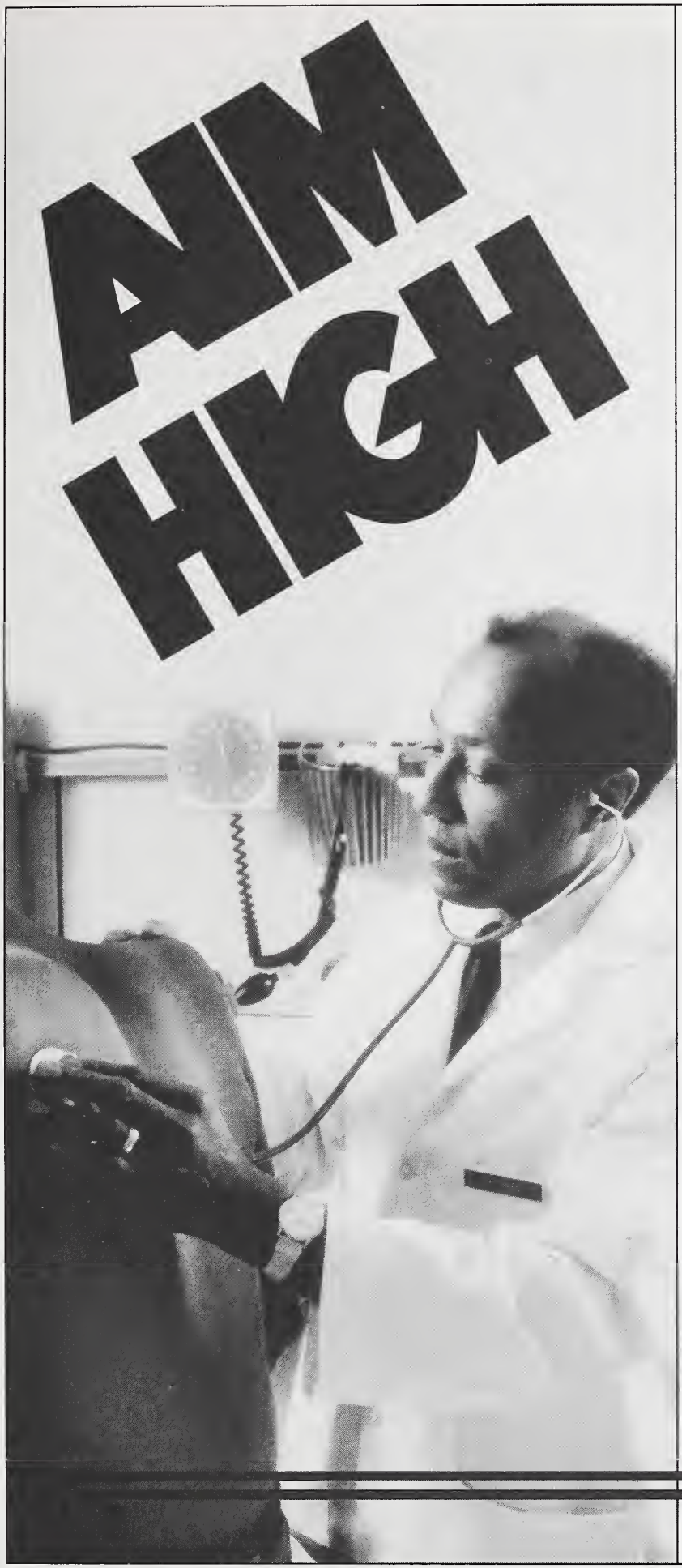
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The Journal
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Rx for a good night's sleep: diagnosing and treating sleep apnea

● VERA DORDICK

Sleep may have been "tired nature's sweet restorer," to 18th century poet Edward Young, but such sweet sleep eludes millions of Americans every night because of obstructive sleep apnea.

As many as 15 million Americans may have sleep apnea, which has existed for centuries, but has been recognized as a disease only for about 20 years. Scientific and technological advances have opened the way for detecting and monitoring these disorders, says Dr. Mark Dyken, assistant professor of neurology and director of the University of Iowa Sleep Disorders Laboratory. "The sleep studies that are now possible supplement what little history a physician can get about the disorder," he notes.

Widespread effects of sleep disorders

"Interest in sleep apnea has accelerated because of growing evidence that people who have it are at an increased risk of hypertension, stroke, heart attack and heart failure," says Dr. Virend Somers, UI assistant professor of internal medicine and cardiovascular specialist. Sleep apnea causes a lack of oxygen and related bodily changes that are dangerous for cardiovascular health, especially if they go unrecognized and untreated, he adds.

In fact, sleep apnea and sleep disorders and their related effects are so widespread that the National Institutes of Health has awarded UI researchers a grant to educate medical students, residents and primary care physicians, as well as the general public, about the prevalence and potential hazards of sleep disorders and treatments for them. Somers and Dyken also are developing a continuing medical education component to this project.

To find out what predisposes people with sleep apnea to these problems, UI researchers began exploring the relationships among the various aspects of the condition. First they studied normal, awake volunteers and monitored the effects of decreased oxygen on the body and found that sympathetic nerve activity (SNA) and blood pressure increase markedly. "We also defined that blood pressure normally falls during sleep and SNA decreases, except during REM sleep," Somers says.

High blood pressure and sleep apnea

Patients with sleep apnea, however, have high blood pressure and SNA while awake, which go even higher during sleep. "When they're sleeping they stop breathing and the normal structure of sleep changes — SNA rises to extraordinarily high levels and blood pressure increases.

The combination of stress from low oxygen, carbon dioxide retention, high SNA, high adrenaline and very high blood pressure are damaging to the heart and blood vessels. "It's important to remember that this condition can go undetected for decades," Somers adds.

Sleep apnea can be easy to diagnose and treatment can have a major positive effect on a patient's quality of life, the researchers say. Certain characteristics can help practitioners identify patients who might have a problem with sleep apnea. "The classic case is a middle-aged man who is overweight, who snores, is often sleepy and who might have large tonsils or excess tissue in the throat," Dyken says. However, thin, healthy people can also have sleep apnea, as can children.

Another indicator may be hard-to-control blood pressure. "We would estimate that about one-third of the people with high blood pressure have significant sleep apnea," Somers explains. Treating the apnea can also have a positive effect on blood pressure lev-

The IMS Education Fund has designated this article as the Henry Albert Presentation Award for April 1997.



VERA DORDICK
Ms. Dordick is assistant director of Health Science Relations at the UI College of Medicine.

Rx for a good night's sleep: diagnosing and treating sleep apnea

continued

els. "In many cases, blood pressure medications can be reduced. Patients feel more rested and there is good evidence that cognitive function and other aspects of life quality improve," Somers explains.

Chronically sleepy patients

These quality of life issues and public health concerns related to sleep disorders are very important. "Pathologic sleep deprivation is dangerous. About 1,500 people die every year because they fell asleep while driving and another 42,000 accidents are caused by sleepiness and fatigue. Billions of dollars are lost annually due to people falling asleep on the job, lost productivity or errors," Dyken explains.

In fact, patients who are "deadly sleepy" aren't fully aware that they're sleepy because the condition is chronic. "To live you have to have sleep and you have to have oxygen. In people with sleep apnea, the body can't do both well, so it compromises. It goes into lighter states of sleep in which the episodes of apnea are not as bad and consequently these patients don't get good sleep. They can sleep for long periods and still be tired," Dyken explains. Patients with severe sleep problems lose their baseline and don't know when they're falling asleep. They can have "sleep attacks" and yet may deny falling asleep.

Cardiovascular disease and sleep apnea

Clinicians should take special heed of patients who are chronically sleepy, particularly because people with sleep apnea are prone to cardiovascular disease. Practitioners can help patients with sleep disorders in a number of ways. "Encourage them to practice good sleep hygiene and keep a sleep diary," Dyken says. Ask patients about the time they go bed, their average length of sleep, waking time, quality of sleep and the number of times they woke up and what the cause was. "Also ask if they ever doze off while driving, in front of the television after dinner or in front of the computer at work," he says. Patients with sleep problems should also get regular exercise, lose weight if necessary, sleep on the side and avoid alcohol and sleeping pills.

CPAP treatment

If these steps do not improve the patient's situation, further investigation with sleep studies is necessary. In general, there are no good medications for sleep apnea, and Continuous Positive Airway Pressure (CPAP) is the most widely used treatment. CPAP treatment involves wearing a mask attached to a small machine that emits a gentle column of air to help keep the airway open. It has been shown to profoundly decrease blood pressure and SNA activity in sleep apnea patients to the point that it approaches normal levels, Somers says. "We're currently exploring whether CPAP treatment can lower blood pressure in the long-term and there are some indications that it is indeed effective," he says. For those who cannot tolerate CPAP, effective treatment can include a surgical alternative that involves removing excessive tissue from the back of the throat or a tracheostomy. IM

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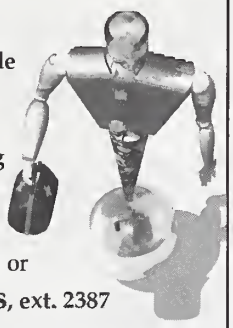
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Salute to Dr. Richard Caplan

The April 1971 issue of the *Journal of the Iowa Medical Society* was significant. With that issue Dr. Richard Caplan began writing his columns entitled "Educationally Speaking". His initial statement indicated he had been asked by the Society to prepare for each issue of the journal some news and comments on continuing medical education. After a short commentary, a listing of CME opportunities was presented, most of the opportunities sponsored by the UI College of Medicine. It afforded an excellent review of courses available to physicians to fulfill their obligations in CME.

After a few years the format changed to a full-page commentary directly (and sometimes indirectly) related to the subject of medical education. Dr. Caplan's remarks attest to his vast knowledge of medicine, the humanities as well as philosophy. As time passed the monthly columns became more broad in their scope; more philosophic, more along the theme of medical humanities, reflections upon the author's personal experiences and sentiment. The writings often presented subjects which challenged the reader.

The January 1992 issue of *Iowa Medicine* presented a new challenge to Dr. Caplan. He had relinquished his commentaries on continuing medical education to Dr. Richard Nelson who succeeded him as the associate dean of continuing medical education at the College of Medicine. Dr. Caplan's new page was entitled "The Art of Medicine" appearing in months that alternated with Dr. Nelson's "CME Notebook". The new role of Dr. Caplan was to "focus his energy increasingly in the art of learning that addresses what used to be called the art of medicine . . . completing and making whole an ancient profession devoted to healing the wounds and illnesses of individuals and society." With skill in his writing and the expertise in knowledge of the humanities that mission has been accomplished.

Now a new era emerges. Retirement will be a new facet of Dr. Caplan's life. His final column appears in this issue of *Iowa Medicine*, the April issue which traditionally has been dedicated to the College of Medicine. Now it is dedicated as well to Dr. Caplan. We of the journal staff, as well as Iowa Medical Society, salute you, Dick, for the wisdom, the challenges, the great asset you have been to *Iowa Medicine*. In a personal vein, I thank you for all the encouragement and assistance you have given to me. We hope your retirement will be filled with pleasure. IM

The April issue which traditionally has been dedicated to the College of Medicine is dedicated as well to Dr. Caplan.



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Farewell

This column began in 1971 when my new role as director of CME for the College of Medicine was off to a roll. The dean, Dr. Jack Eckstein, suggested the IMS journal might be willing to publish a regular CME announcement. It was. My little blurb of CME news expanded by 1973 to a one-page column of personal reflection on all sorts of things linked to medical education.

The 10-times-a-year column was named by the editor, "Educationally Speaking", which he later changed to "Our Man on Education", then "CME Notebook" and finally "The Art of Medicine". That last change coincided with my leaving the CME office after 21 years and with my greater involvement in an evolving program I had unknowingly begun and then nurtured. Today we call it the Program in Biomedical Ethics and Medical Humanities, providing instruction in biomedical ethics, medical history and literature-and-medicine.

Directing CME moved in 1991 to Dr. Richard Nelson, who now includes that task within his duties as executive associate dean. The *Journal of the Iowa Medical Society*, now *Iowa Medicine*, divided the regular one-page assignment between us, so that he wrote about CME and I was allowed to reflect freely. When the IMS reduced publication from 12 to nine issues annually, my assignment dropped to four issues, which helped me "practice" for the arduous job of becoming a retiree in July. When I count up the columns, they total 239. I'd certainly had no idea of such an effort or outcome when it all started.

As you must sense, this historical review leads to my farewell to this column. It became my friend and incentive, a goad and a satisfaction. I'm much indebted to our editor, Dr. Marion Alberts and to Mr. Don Neumann, Ms. Tina Preftakes and their able editorial helpers through the years. And of course to the readers. It's always a delight to learn, now and then, that someone out there has read and felt some appreciation for my scribblings.



RICHARD CAPLAN, MD

When I count up the columns, they total 239. I'd had no idea of such an effort or outcome when it all started.

The changes in the science and practice of medicine since 1971 have been astounding and challenging, providing plenty of raw material to fuel my ruminations. The excitement and frustration of change will undoubtedly continue. So will the delight for physicians in offering better help to patients for prevention, alleviation or cure.

If you've read this far, then you surely meet the definition of a reader. So I bid you a fond farewell and offer my sincerest wishes that your professional and personal life will continue to be useful and satisfying. IM

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(Continued next page)

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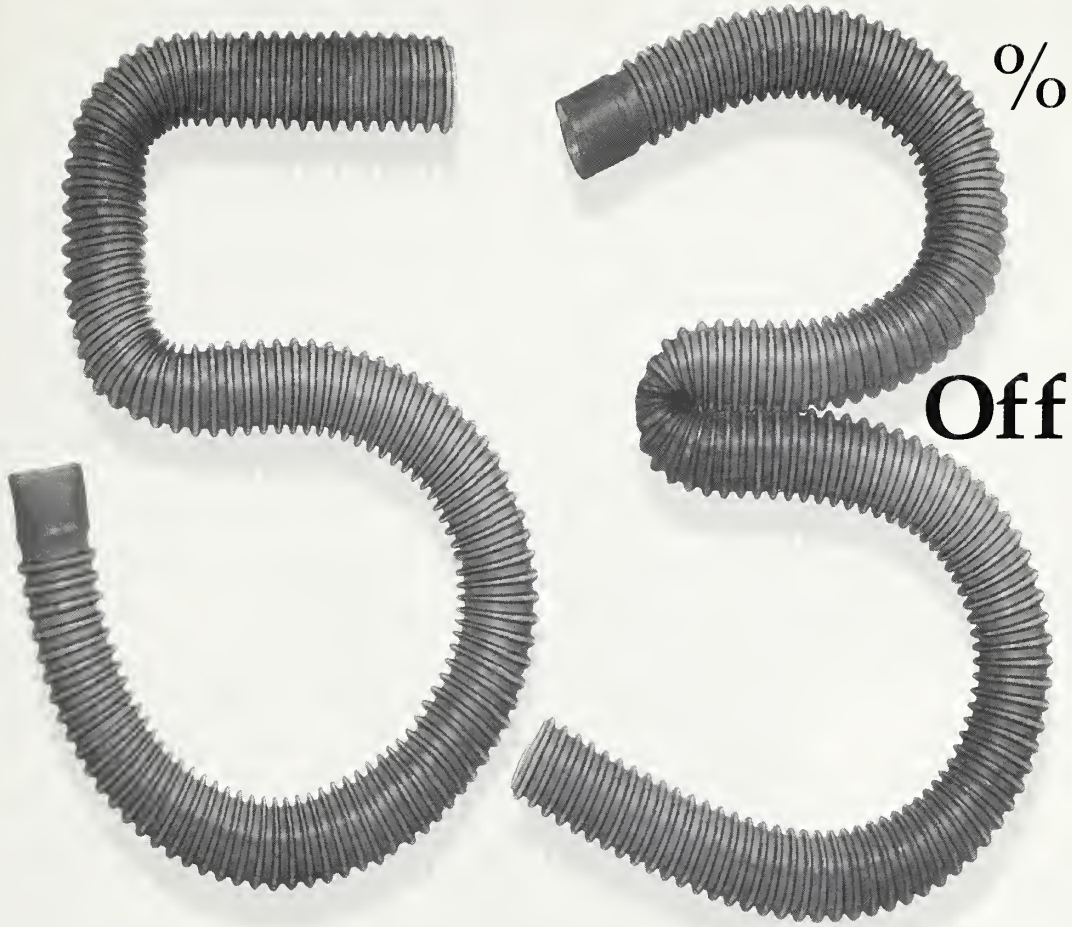
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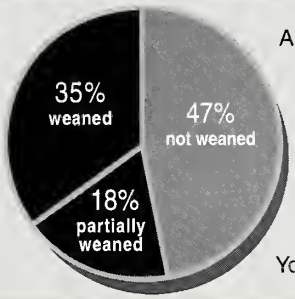
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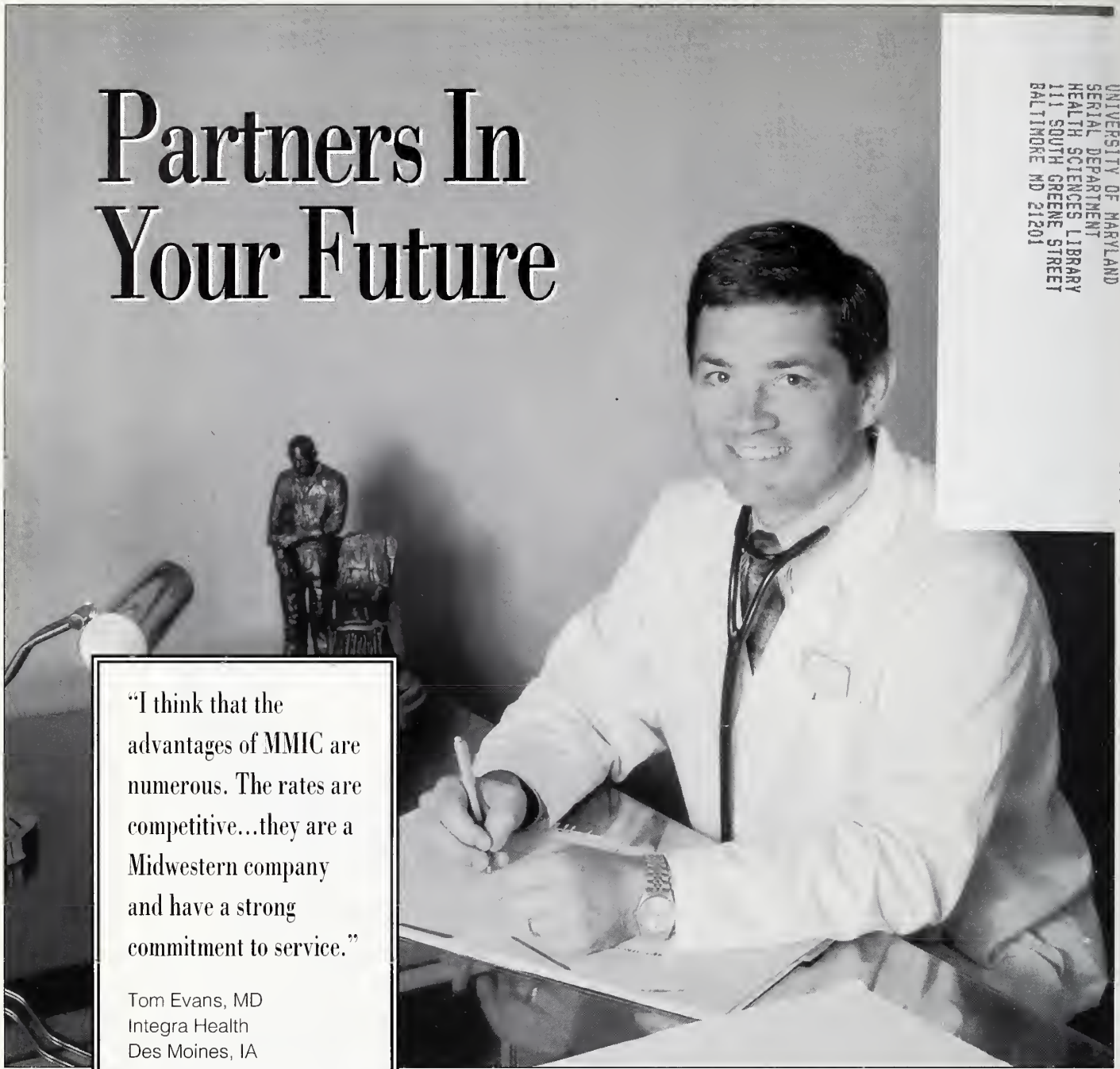
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Iowa Medicine
JOURNAL OF THE IOWA MEDICAL SOCIETY | MAY–JUNE 1997

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The 11th Commandment:

Thou shalt create a compliance program

See page 192 for an in-depth article by two experts in this field who say every health care organization, including solo practitioners, needs to adopt some type of compliance plan

IMS successful with Tort Reform, Point-of-Service Bills

Status of key bills in the Iowa Legislature, see page 184

New horizons in diagnosis and treatment of Alzheimer's disease (see page 199)

STACKS

"Baby, Think It Over"

See page 191 for a list of people and organizations who have contributed dolls to Iowa schools

The IMS and IMSA have worked diligently to educate teens about the realities of parenting before teens exercise behaviors which result in pregnancy. The goal of the Baby Think It Over program has been to ensure that parenting is a dream not a burden.



Pictured at right: William McMillan, MD, IMS president and Karen Messamer, IMSA president

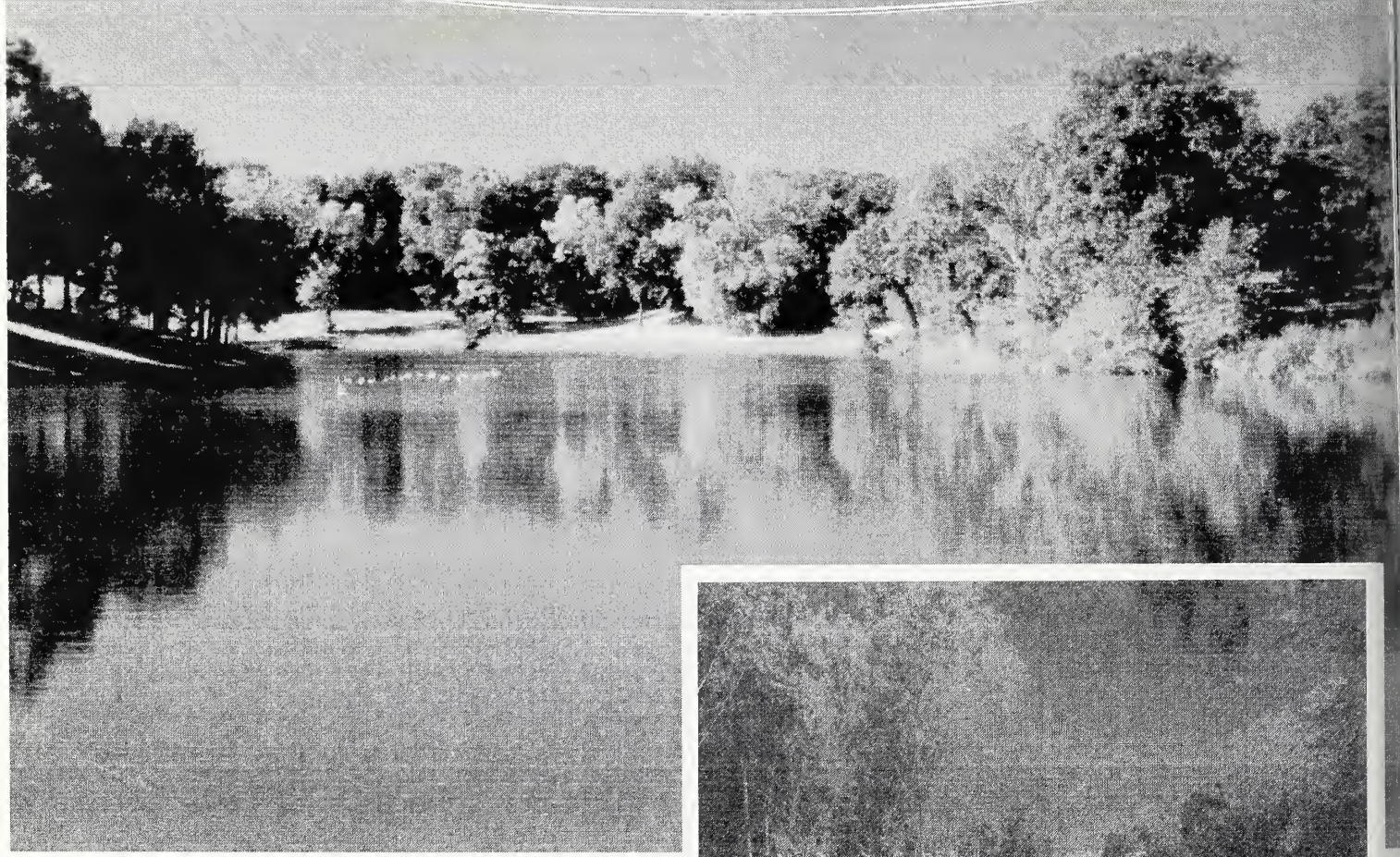
Mercy Health Services: an Iowa physician network 181

IMS officers and award winners 182

Hot web sites are reviewed on "New on the Net" 179

Teaching hospitals get credit for undercoding 186

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IMS *DEADLINE* news

May-June, 1997

Late-breaking news of interest to Iowa physicians

•**IOWA PHYSICIANS WON A SIGNIFICANT VICTORY** in the Iowa Legislature on Friday, April 18 with passage of HF 693, the IMS tort reform bill. After more than five hours of debate, the bill passed the Senate Friday afternoon on a vote of 30-17. In its final form, the bill reduces the statute of limitations for minors to "8 plus 2" years so the normal two-year statute of limitations starts running when a child reaches age eight. Iowa physicians are urged to call or write senators who voted for the bill. Senator Larry McKibben of Marshalltown deserves special recognition for successfully managing the bill in the Senate. The vote was: Ayes — Angelo, Bartz, Behn, Black D, Boettger, Borlaug, Douglas, Drake, Flynn, Freeman, Hedge, Iverson, Jensen, King, Kramer, Lundby, Maddox, McCoy, McKean, McKibben, McLaren, Redfern, Redwine, Rehberg, Rensink, Rife, Rittmer, Schuerer, Tinsman, Zieman. Nays — Connolly, Dearden, Deluhery, Fink, Fraise, Gettings, Gronstal, Halvorson, Hammond, Hansen, Harper, Horn, Judge, Kibbie, Neuhauser, Palmer, Szymoniak. As of press time, the legislature was expected to adjourn sometime the last week of April. However, legislators can be reached at home after the session ajourns for the year.

•**THE IOWA MEDICARE OFFICE** is looking for someone to fill a new Medicare director position. The new director will work with Dr. John Olds. Physicians interested in hearing more about the position should contact Kevin Spitzig, human resources, Blue Cross and Blue Shield of Iowa, 515/245-7823.

•**IOWA PHYSICIANS HAVE BEEN CALLING IMS HEADQUARTERS** regarding the previously-announced July 1, 1997 deadline for Iowa physicians to switch to electronic billing. Iowa physicians should know that, due to changes in the structure and mission of CHMIS, the deadline will not be enforced. For an update on the current status of CHMIS, see page 187 of this issue.

•**IOWA GOVERNOR TERRY BRANSTAD AND ATTORNEY GENERAL TOM MILLER** received the Iowa Medical Society's Washington Freeman Peck Award at the Saturday, April 19 IMS banquet, but didn't receive them in the usual way. Since the awards were given for Iowa's lawsuit against tobacco companies, they were handed out by The Extinguisher, the AMA's butt-kicking, anti-smoking superhero. "I'm speechless," said Governor Branstad as he took his award from the 6'5" muscle-bound, purple-caped Extinguisher.

•**THE PORTION OF THE PARENTAL NOTIFICATION LAW** which required physicians who provide prenatal care to minors to offer a video outlining options has been altered. Under the modification of the law, the video must be offered only to minors who are seeking abortion services. Physicians with questions about this change in the law may call Becky Roorda at the IMS, 515/223-1401 or 800/747-3070.

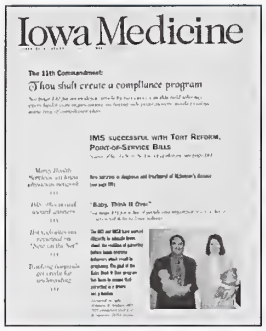
•**IF YOU ARE AN AVERAGE PHYSICIAN,** about 20% of your patients currently use electronic mail, reports a recent issue of *California Physician*. Up to half your patients may have access to the Internet. IMS staff are hearing from physicians whose patients arrive for appointments carrying a stack of printed information obtained from the Internet.

•**CONGRATULATIONS TO THE WOODBURY COUNTY MEDICAL SOCIETY,** which celebrates its 125th anniversay at its annual meeting May 9th.

For more information about any *DEADLINE* news item, call Chris McMahon at IMS headquarters, 515/223-1401 or 800/747-3070.

Iowa Medicine

JOURNAL OF THE IOWA MEDICAL SOCIETY MAY–JUNE 1997 / VOLUME 87 / 5



About the Cover

William McMillan, MD, IMS 1996-97 president and Karen Messamer, IMS Alliance 1996-97 president, hold Baby Think It Over dolls. To date, over 300 dolls have been donated to Iowa schools by physicians, physicians' spouses and others.

Results of the survey of Iowa practicing physicians will appear in the July–August issue.

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Feature Articles

A matter of being fit 177

In his farewell speech to the House of Delegates, the outgoing IMS president encourages physicians to become fit to serve and lead. *William McMillan, MD, IMS president*

New on the Net 179

Tired of shopping the conventional way? Shop online! Guide to health economics on the Internet

Mercy Health Services: an Iowa physician network 181

The strength of this network lies in its local community health care systems which partner with physicians and community hospitals (ninth in a series).

Current Issues 182

IMS officers elected, *p. 182* . . . Status of key bills in the Iowa Legislature, *p. 184* . . . New OIG office planned for Des Moines, *p. 186* . . . What's expected July 1 with CHMIS?, *p. 187* . . . CLIA requirement clarified, *p. 188*

Thou shalt create a compliance program 192

Compliance programs are necessary for large and small physician practices according to these authors. *Michael Reiling; David Glaser*

BTIO Contributors 191

Iowa physicians, physicians' spouses, community groups, churches, businesses, professional organizations and others have given $80,000 worth of Baby Think It Over dolls to Iowa schools.

Alzheimer's disease: new horizons in diagnosis and treatment 199

We are in the midst of an explosion in research on all facets of Alzheimer's dementia. Estrogen therapy in postmenopausal women and NSAIDs show early promise.

Lynn Rankin, MD

Departments

Liability protection . . . is it possible? *Jerry Foster* 197

Spring: a time for renewal *Marion Alberts, MD* 203

Continuing education on health policy *Richard Nelson, MD* 205

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Coming this summer to a city near you . . .

The ABCs of Compliance Programs

June & July (see calendars below for dates)

10:00 am-3:00 pm (lunch provided)

$79 for IMS members; $158 for nonmembers

With all the attention on audits and post-payment review, the Iowa Medical Society continues its commitment to educate and assist physicians and their staff on this important issue. Attend this 4-hour seminar and return to your office with practical guidance on the creation and implementation of an effective compliance program to reduce your risks if audited or reviewed. The program will be presented by Barb Cannon and Barb Pierce, IMS practice management staff.

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- Which office staff need to be key players
- How to effectively manage and monitor the program once it is in place
- When to seek help from attorneys or consultants
- What resources are available from the IMS and others
- And much more!

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22	23 ★ Mason City	24	25	26 ★ Sioux City	27	28
29	30 ★ Ottumwa					JUNE

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JULY		1	1	3	4	4
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The cost of this program is $79 for IMS members; $158 for nonmembers.

There are two ways to register for the ABCs of Compliance Programs:

1. Fill out the form below, indicating which program you plan to attend. Send payment to IMS Services, Attn: Sherry Johnson, 1001 Grand Avenue, West Des Moines, IA 50265 or pay by credit card (see details below).
2. Log onto the IMS web site at http://www.IowaMedicalSociety.org and find the Events & Seminars section. There is a generic registration form you can fill out. Remember to type in which program you plan to attend. (See the program dates and locations below.)

Name_____

Address_____

City, State, Zip_____

Telephone_____ Fax_____

Program dates and locations (Please indicate the seminar you plan to attend)

_____June 5	Marshalltown Medical & Surgical Center, Classroom A
_____June 16	Des Moines Mercy Education Center, Upper Level
_____June 19	Dubuque Finley Hospital, First Floor Auditorium, Sections C through E
_____June 23	Mason City Holiday Inn, Partridge Room
_____June 26	Sioux City, Marian Medical Center, Toy Medical Building, Lower Level
_____June 30	Ottumwa, Indian Hills Community College, Bennett Regional Training Center, Room 10(
_____July 14	Omaha, St. Joseph Center for Mental Health, Seminar Room
_____July 17	Waterloo, Allen College, Medical Staff Room
_____July 21	Burlington Medical Center, Center for Rehab in West Burlington, Blackhawk Room
_____July 24	Fort Dodge, Trinity Regional Hospital, Oleson Conference Room
_____July 28	Cedar Rapids, Mercy Education Center
_____July 31	Davenport, Scott Community College, Urban Center, Room 206

Payment method

_____Check or money order made payable to IMS Services Amount enclosed_____

_____Credit card (circle one) MasterCard VISA American Express

Credit card number_____ Expiration date_____

A matter of being fit

How fit is the health of our organization and the health of the physicians who deal with the health of the nation? Less than half of the physicians practicing in America belong to the AMA, though 90% live by decisions made and refined by the AMA in the areas of business, politics and ethics.

The ethical core of the AMA has been an ongoing concern. Let's consider the inner workings of the IMS. What keeps us together and makes us tick? On a personal level, we must identify the core values that form the foundation of a strong family and build a platform for healthy, productive work. We must restore balance to our lives.

How does this apply to the Iowa Medical Society? Once the core values, family, health, God and community are identified the right path is easy. Other demands on time, attention and resources assume a reasonable balance. Those same core values stabilize and balance our IMS.

For example, considering the issue of physician-assisted suicide, economists tell us most health care resources are consumed in the last six months of life. Advocates for public health would suggest a cost effective end to a patient's suffering. But, a journey to our ethical roots affirms the patient's right to dignity and freedom from pain which can almost always be achieved through appropriate care. The part of the system that is wrong is the pressure to switch the physician's ultimate loyalty from a patient's health to a population's health.

Another area in need of commonly shared core values is medicine as a profession versus medicine as a business. Where is our ethical code? Specifically, it tells us that healing can never be a business, health a commodity or the special relationship with patients a contract. Our core values can guide the resolution of conflicts or loyalty, moral complexity, violations of informed consent and confidentiality inherent in certain forms of managed care.

How do we find and restore organized medicine's ethics? Leadership starts in our offices where we demonstrate the importance of confidentiality, patient dignity and service. Your leadership in shaping the values of medical practice and health care delivery will help us meet the changes society throws at us while we maintain our ethics and dignity.

Healing can never be a business, health a commodity or the special relationship with patients a contract.

The IMS needs you. We need the collective wisdom of our profession to plot a course true to those core values that elevate our calling. Recruit young members and under-represented members to be counted with the IMS and the AMA.

Lastly, become a community resource. Be part of the town you live in. It is, after all, a matter of being fit. Fit to serve, fit to lead, fit to be the best physicians we all can be. IM



William McMillan, MD
IMS President

With Kids And Diamonds,



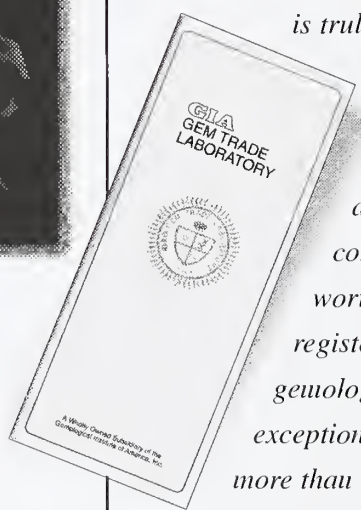


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A GIA certificate is similar to a report card; it lists and grades a diamond's color and clarity, but it does not tell you about the brightness or grade the cut of the diamond.

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New on the Net

Avoid the mall – shop online!

Those days of weary feet, jostling crowds and lost parking spots may be over. Shopping online provides you with the comforts of home and the shopping selection of a mall.

No need to be frightened about those horror stories of online purchases going awry. Shopping online is almost like ordering from a catalog over the phone. Established sites will provide security measures to ensure your transactions are as secure as any other credit card purchases.

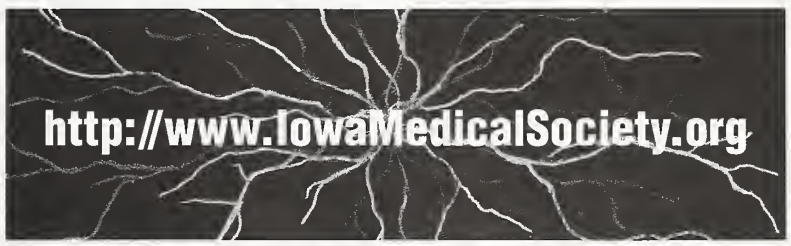
What you need to shop online is a credit card and a browser that provides for encryption technology. Netscape Navigator 1.1 and above, Microsoft Internet Explorer 2.0 and above and America Online 3.0 all provide this security feature.

Sensitive information such as your credit card number will be encoded into gibberish before transmission and decoded by the retailer. These transactions will be preceded by an advisory notice or visual cue. In Netscape the key at the far left corner changes to blue and appears whole to indicate the transaction is secure. If the site is not secure, the key appears broken.

Stick with established catalog retailers like Sharper Image (*www.sharperimage.com*), Eddie Bauer (*www.ebauer.com*) or Columbia House (*www.columbiahouse.com*) to ensure security.

A few net-commerce industry groups, such as "shop.org" (*www.shop.org*) and "eTrust" (*www.etrust.org*), have developed security approval programs and directories of secure sites. Among their listed sites you'll find places to shop for everything from CDs and videos to greeting cards to golf equipment to gourmet foods and wines. For gifts, check out "Cybershop" (*www.cybershop.com*), an online department store with specialty boutiques for wedding and birthday gifts.

See IMS Internet Hints on the IMS web site for more links for shopping on the Internet.



Linking IMS physicians to the information they need

Hot sites

Guide to health economics on the Internet: "Patty Peeples' Guide to Health Economics, Medical and Pharmacy Resources on the Net" looks like it's done by an web design amateur, but its contents are far from unprofessional. The guide lists links to health economics sites about medical outcomes data, market reports, practice guidelines and policy sources. Some links are outdated, but this site is a good starting point for searching out this type of information on the Internet. The site also lists links to employment sources, journals, medical libraries, government health care sites and health care companies.
http://www.exit109.com/~zaweb/pjp/index.shtml

GolfWeb: Anyone with even the slightest interest in golf will find something on this site. With pro news, tips for improving your game and a complete online shop, "GolfWeb" is aptly named the Internet's premier golf web site. Watch out for large graphics and a slower download time. *http://www.golfweb.com*

Health news: *Modern Healthcare* magazine is on the Internet. Just like its print sibling, the *Modern Healthcare* web site is full of current health news articles, updated every Wednesday. The site also provides short news clips daily and an archive of its past issues. *http://www.modernhealthcare.com* IM

IMS staff members are on the watch for sites that might interest Iowa physicians. Staff members visit all **Hot sites** *to make sure they have useful information and reasonable download times. Suggestions for* **Hot sites** *can be sent to Melanie Finke by e-mail at communic@netins.net or by telephone at 800/747-3070.*

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Mercy Health Services: an Iowa physician network

(Ninth in a series)

The Mercy Health Services Physician Network was initiated in 1986 when Marion Medical Services in Sioux City was formed. The network was expanded in 1987 by the formation of Mercy Family Care Network in the Mason City area. Today there are 177 providers including 125 physicians, 35 mid-level providers and 17 family practice residents.

According to Jay Mixdorf, MD, vice president of Physician Relationships and Services, growth of the physician network began when physicians sought management support services. More recent growth has been to secure physician access to patients via insurance products and maintain regulatory compliance.

Primary care and specialty services

Primary care and specialty services are provided in 57 clinics serving 50 mostly rural communities with over 500,000 visits annually. The Mercy Health Service Physician Network is a member of the Mercy Regional PHO which represents nearly 700 primary care and specialty physicians in Iowa for third party payer contracting.

The Physician Network is sponsored by Mercy Health Services, one of the largest Catholic health care delivery systems in the country with regional corporate offices in West Des Moines. The strength of the system lies in its local community health care systems which partner with physicians and community hospitals.

Wide-ranging goals

The goals of the network are clearly defined, as explained by Dr. Mixdorf:

- Develop a strong voice for primary and specialty care;
- Recruit/retain well-qualified providers;
- Further develop physician leadership;
- Develop innovative and productive relationships with providers and organizations that meet community health care needs;
- Develop an integrated governance and management structure;
- Position the network for state and federal health reform as the provider of choice in the managed care environment;
- Develop a group practice culture/identity;
- Enhance quality of life for physicians.

Numerous successes

The network has enjoyed success in many areas. One unique situation Mercy Health Services is involved with is the statewide Health Information Network which links physician clinics, community hospitals and referral hospitals for sharing data electronically across 70 sites. The network has also joined IBM in developing a user-friendly electronic medical record which is being used in several physician clinics. The most important success, however, according to Dr. Mixdorf, is the ability to deliver accessible, quality health care in Iowa communities.

Support services enhance professional growth

The Mercy Health Services Physician Network offers a variety of relationship options ranging from practice acquisition and employment to basic affiliation for access to insurance products and consultation services. Management service agreements and joint venturing with independent practices on specific projects are also available. Joe Wilkinson, regional director of Physician Relationships, sums it up in these words, "The Mercy Health Services Physician Network is dedicated to providing the support services which assist our physician partners in achieving professional success." IM

"The strength lies in community health care systems which partner with physicians and hospitals."

KEY CONTACTS:

Mercy Health Services
West Des Moines
515/224-3260

Jay Mixdorf, MD
Vice president of Physician Relationships and Services

Joseph Wilkinson
Regional director of Physician Relationships

If you know of other innovative practice arrangements we should write about in Iowa Medicine *— especially those controlled by physicians and positioned to compete in the managed care market — call Barb Cannon or Chris McMahon at the IMS, 515/223-1401 or 800/747-3070.*

IMS Update

News at a glance

The Iowa Tobacco Free Action Team — which includes the Iowa Medical Society — has been awarded a $600,000 grant from the Robert Wood Johnson Foundation. IMS participated in the grant application, including hosting a luncheon during the site visit by RWJ representatives. The grant will be used for an educational campaign to prevent tobacco use by Iowa youth.

The AMA's recent "Ethics in Medicine" conference was a rousing success. The conference was well-covered by the media, with 40 reporters attending.

IMS officers elected

Harold Miller, MD, a Davenport family physician, was installed as president of the Iowa Medical Society on Sunday, April 20. The installation ceremony concluded the Society's three-day House of Delegates and Scientific Session at the Embassy Suites, Des Moines. Dr. Miller is a native of Iowa and has practiced family medicine in Davenport since 1977. He earned his undergraduate degree at Iowa State and attended University of Iowa College of Medicine.

Other physicians elected to office are:

President-elect (1-year term): John Brinkman, MD

Vice president (1-year term): Jose Angel, MD

Trustee (3-year term): Hunter Fuerste, MD

House Speaker (1-year term): Tom Throckmorton, MD

Vice speaker (1-year term): John Sutherland, MD

AMA delegate (2-year terms; elect 2): Tom Graham, MD and Bryan Pechous, MD

AMA alternate (2-year terms; elect 2): Michael Disbro, MD and Janice Kirsch, MD

AMA alternate: James Hubbard, MD was elected to fill the slot vacated by Thomas Graham, MD

District Councilors (3-year terms):

- District 3 — Eugene Kerns, MD
- District 7 — Thomas Spragg, MD
- District 8 — David Carlyle, MD
- District 12 — William Kuyper, MD
- District 15 — Kathryn Opheim, MD

IMS awards given at annual banquet

Thomas Foley, MD was awarded the 1997 IMS Merit Award at the Society's annual banquet Saturday evening, April 19. Dr. Foley, a Marshalltown general surgeon, has represented IMS for years on several state committees relating to emergency services and trauma system development. He has been an extremely effective representative for physi-

News from Iowa Medical Group Management Association (IMGMA)

Where does the money go?

Frequently these days as we attempt to provide the most cost effective and efficient eare to our patients, we wonder where the money is going that we are saving. Is it being redirected to the uninsured? Is it going for reductions in the premiums we pay? Will two fewer days in the hospital mean someone else will receive care who otherwise would not?

This question has been answered for us recently in the case of the State of Iowa Mental Health Access Plan. As you will recall, Iowa received a HCFA waiver for a managed mental health carve out. The first year audit by Deloitte & Touche LLP is now public. We find that the plan reduced payments to doctors, hospitals and clinics by 38% (over $18 million) in the first year.

MBCI, the Iowa contactor running the Mental Health Access Plan, spent over $10 million on administration and $31 million on services. The state and federal governments saved $9 million. The $10 million spent on administration by MBCI does not include additional administrative costs incurred by doctor's offices, clinics and hospitals for time spent on the telephone with reviewers and filling out additional paperwork. We now know where the money goes.

(This article was written by Dana Petrowsky, IMGMA executive director.)

cians and patients and has taken a leadership role in development of these systems.

Also at the banquet, Dr. Dennis Boatman, a Cedar Rapids urologist, was the recipient of the 1997 Physician Community Service Award. Dr. Boatman has served in leadership roles with United Way of Eastern Iowa, the University of Iowa Foundation, the Cedar Rapids Chamber of Commerce and Theatre Cedar Rapids. He was the driving force behind a fund-raising campaign which led to establishment of the Madge Phillips Center for homeless women and children.

The 1997 Outstanding Iowa Medical Office Administrator Award was given to Kris Zeller, business manager of Cardiovascular Medicine PC in Davenport. Ms. Zeller was nominated by Philip Habak, MD.

The Washington Freeman Peck Award was given jointly to the Office of the Governor and the Office of the Attorney General for their lawsuit against tobacco companies. Senator Elaine Szymoniak received the Sanford Award, which is given annually to a lay person for outstanding contributions to the field of health care. Sen. Szymoniak was a member of the Health Regulation Task Force and the Council on Human Services. IM

SPECIALTY SOCIETY UPDATE

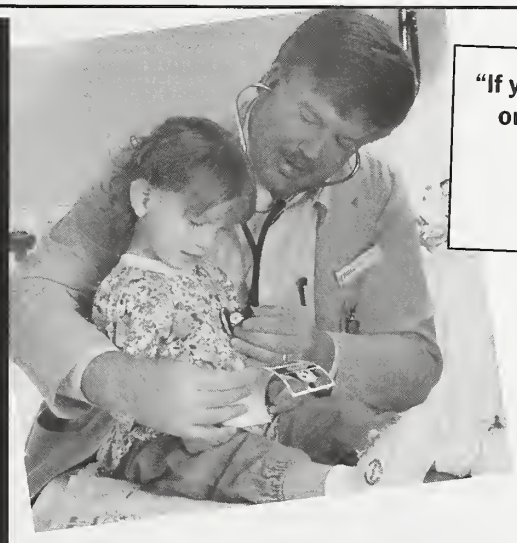
The AMERICAN MEDICAL DIRECTORS, IOWA CHAPTER Board met in April. The fall membership meeting will be held in Iowa City. Future educational goals include learning correct coding and modifiers for Medicare billing and working with the State Department of Inspections and Appeals on nursing aid training.

The AMERICAN COLLEGE OF CARDIOLOGY, IOWA CHAPTER Board met in April. Margaret Verhey, MD and Al McClatchey, associate administrator, Iowa Heart Center, Des Moines, will work as an administrator/doctor team representing the ACCIC on the Medicare Carrier Advisory Committee.

The IOWA SOCIETY OF ANESTHESIOLOGISTS Spring Anesthesia Update on April 5 was attended by 70 physicians, anesthesia technicians and exhibitors at the Des Moines Convention Center.

The IOWA SOCIETY OF REHABILITATION MEDICINE held its Spring Meeting on April 4 at IMS headquarters. Pending federal legislation was discussed and a demonstration of medical research and rehab patient care web sites was presented.

For more information, contact Dana Petrowsky or Dave Furneaux at 515/223-2816 or 800/728-5398.



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Legislative Affairs

News at a glance

The Governor's office and the Iowa Department of Public Health are convening a conference entitled "A Barn Raising for Public Health: Building on Iowa's Heritage in the 21st Century" at Drake University in Des Moines on June 5–6, 1997. Key public and private-sector health care providers, purchasers, payers and consumers will attend to discuss the protection and promotion of the public's health and begin to resolve the emerging health issues of the 21st century. The IMS will have a display booth featuring the Society's work on combatting domestic violence and child abuse.

Status of key bills

Adjournment of the Iowa Legislature is expected by the end of April. April 4 was the second funnel deadline when most bills must have passed one house and been approved by a committee in the other house to remain alive for the session.

Tort Reform Passes House–(HF 693)

The IMS statute of limitations amendment was adopted by the House on Tuesday, April 1 on a vote of 58 ayes, 42 nays. All Republican representatives, except for Dinkla, voted in favor. Democrats voting for the amendment: Bukta, Mascher, May, Mertz and O'Brien. Please call or write and thank your legislators who voted for this amendment.

Thanks is in order for Representative Clyde Bradley (R-Camanche) who was lead sponsor during debate and successfully fended off attacks from opponents. Other cosponsors were May (D-Kensett), Hansen (R-Council Bluffs), Mertz (D-Ottosen), Jacobs (R-West Des Moines), Lamberti (R-Ankeny) and O'Brien (D-Boone).

Thanks also goes to Speaker of the House Ron Corbett (R-Cedar Rapids) and Majority Leader Brent Siegrist (R-Council Bluffs) who provided leadership to their colleagues on this bill and helped fight off amendments proposed by the plaintiff's bar.

Credit is due to Representative Jeff Lamberti who was primarily responsible for defeat of the plaintiff's bar amendment to repeal Iowa's collateral source law, sponsored by Representative Mike Moreland (D-Ottumwa). The IMS strongly opposed this amendment and had the assistance of Republican leaders in preventing its passage. All Republicans and Democrats May and Mertz voted against the amendment. Iowa's collateral source law is one of the best in the country and was passed in response to the medical liability crisis of the mid 1970s. This law is considered by experts to be nearly as important as a cap in reducing frequency and severity of liability claims.

Debate on this bill is expected soon in the Senate. The bill is a coalition bill and contains other tort reforms including a statute of repose for manufactured products.

Managed Care Choice

The IMS point-of-service bill, HF 133, providing for patient choice of physician under managed care, has passed the House and has been approved by the Senate Commerce Committee. It is expected to be debated soon by the full Senate. If no amendments are adopted, the bill will go to the governor for his consideration. The IMS has worked for this bill as part of a broad-based coalition which includes business associations, other health care provider associations and insurers who have agreed to this bill as a reasonable compromise.

Worker's Compensation

SF 296, relating to worker's compensation, has passed both houses and will go to the Governor for approval or veto. The bill provides that in the event of a dispute between a worker's compensation insurance carrier and an employee's regular health plan over who should pay the health care bills, the health insurance carrier is required to pay health care providers who have already provided services. The two carriers can then continue their dispute over who pays, without physi-

cians or hospitals being caught in the middle. The IMS strongly supports this bill. It should be noted that since the state is preempted by federal Employee Retirement Income Security Act (ERISA) from regulating self insured health plans, this bill will not provide relief in all cases.

Abortion Notification

HF 121 modifying Iowa's new parental notification of abortion law has been passed by the House and is being considered by the Senate. The bill will make several changes in response to a court challenge of the law passed in 1996. The bill also includes language proposed by the IMS that would eliminate the requirement that physicians who provide prenatal care to pregnant minors offer viewing of a video designed to help the minor choose between keeping the baby, adoption or abortion. Under the language proposed by the IMS, the video would only have to be offered by a physician from whom an abortion is sought by a minor. Because of disagreements among legislators over whether a grandparent could be notified of a minor's abortion instead of a parent, the future of the bill is uncertain.

IMSA Domestic Violence Bill

HF 174, proposed by the IMS Alliance, was approved by a House committee but was not brought up for debate in time for the second funnel deadline. It could be considered next year. HF 174 would have required a warning on marriage certificates that spouse abuse is illegal. IM

CONTACTING YOUR LEGISLATORS

Telephone numbers during the session:

Senators	**515/281-3371**
Representatives	**515/281-3221**
Governor	**515/281-5211**

Write to them at:
STATEHOUSE
Des Moines, Iowa 50319

You may also contact your legislators at home when the legislature is not in session. If you don't know who your legislator is or need your legislator's home address and phone number, call Cheryl Peers of the IMS staff, 800/747-3070 or 515/223-1401.



Dear Colleagues:

I have had the pleasure of serving on the IMS Education Fund Board of Directors for a number of years. I have seen how much this fund has benefited Iowans. I can also see how many needs there are to be met in the near future. Contributions to the Education Fund have not kept pace with the needs of programs the Fund supports.

The principal activity of the IMS Education Fund is the George H. Scanlon Medical Student Loan Fund. Last year $157,790 was loaned to 29 students. Since repayment does not begin for three years after graduation, the amount of repayment income from prior loan recipients is not sufficient to meet the needs of current medical students.

The Fund also supports various scientific and public health education projects such as child abuse identification, physician and public education on family violence, health care for the elderly and drug abuse.

Please join me and your colleagues who have recently supported the IMSEF (see the April issue of *Iowa Medicine* for a list of contributors) by giving in one of the following categories:

Life Member	***$5000 (5-year payment option)***				
President's Circle	***$1000 (5-year payment option)***				
Trustees' Circle	***$500–999 (5-year payment option)***				
Patron	***$100–499***	***Contributor***	***$50–99***	***Other***	***$1–49***

Consider giving back to your profession through the IMS Education Fund today. Send your gift to the IMS Education Fund, 1001 Grand Avenue, West Des Moines, Iowa 50265 or call the IMS (800/747-3070) for more information.

Sincerely,
Paul Seebohm, MD, Fund-raising Committee
Chair of the IMS Education Fund

Medical Economics

News at a glance

A branch office of the OIG will be opened in Des Moines according to HHS Inspector General June Gibbs Brown. Several other offices will also be opened around the country, increasing the number of OIG investigators and auditors by 20% this year. This is a result of the Health Insurance Portability and Accountability Act approved by Congress in 1996.

Medicare payments to managed care plans take the biggest hit under the Clinton administration's fiscal 1998 budget while physicians are the biggest winners as reported in a recent issue of Modern Healthcare. *The White House proposal would reduce projected Medicare payments to hospitals by about $33 billion over the next five years. Physicians will experience $7 billion in spending reductions over the five-year period.*

Good news for teaching hospitals

Teaching hospitals stood eyeball-to-eyeball with the OIG, and the government blinked. According to a recent issue of *Medicare Compliance Alert*, teaching hospitals will now get credit for undercoding when penalties are computed during a PATH (Physicians at Teaching Hospitals) audit.

The OIG retreat comes amid criticism of PATH on Capitol Hill. As of last month, OIG field offices were told to give credit for undercoding in their audits. The credit could shave as much as one-third off PATH overpayments, estimates a teaching hospital compliance officer. OIG has agreed not to audit E & M codes before August, 1995 because HCFA had not issued formal E & M guidelines before that date.

However, it's reported OIG will not budge on a request from the American Association of Medical Colleges that hospitals get credit for claims that were never submitted.

Fraud and abuse bill drafted

The Department of Health and Human Services reports that legislative language has been drafted for the Administration's Health Fraud and Abuse Initiative.

The initiative would:

- Create a new civil monetary penalty for physicians who certify that an individual meets Medicare requirements for partial hospitalization and hospice services while knowing that the individual does not meet such requirements.
- Specify the dollar amount in civil monetary penalties that may be imposed on both participating and nonparticipating physicians.
- Authorize civil monetary penalties to be levied on providers who violated the anti-kickback statute.
- Authorize civil monetary penalties against anyone who knows or should know that they are submitting claims for services ordered or prescribed by an excluded individual.

The initiative would also give the HHS secretary the authority to deny entry into the Medicare program to providers convicted of a felony. The secretary could also collect a fee for all Medicare and Medicaid applicants when they apply for enrollment or re-enrollment. If an application is denied, providers could not re-apply for six months.

Columbia being investigated

Law enforcement officials and several government agencies are investigating an array of business practices at the nation's largest health care company, Columbia/HCA Healthcare Corporation. The company runs about 350 hospitals and treats 125,000 people a day.

The investigation surfaced recently when federal investigators raided Columbia hospitals and doctors' offices in El Paso.

The focus of the investigation appears to be possible upcoding at Columbia hospitals and an examination of whether it is illegal for Columbia doctors with a financial interest in outside medical services such as home care —associated with Columbia—to send patients to them. IM

DATA & TECHNOLOGY

What's up with CHMIS?

Iowa's Community Health Management Information System (CHMIS) was signed into law in April, 1994. The original bill required CHMIS to be implemented in three different phases, with the first phase scheduled to begin July, 1996.

CHMIS required that all physicians, hospitals, pharmacies and other health professionals submit insurance claims electronically through a certified network. The law also required insurance companies (except ERISA regulated payers) to accept insurance claims electronically.

At the time the claim was transmitted from provider to payer, CHMIS planned to copy certain data elements from the claim and store in a centralized data repository. This data base would be used to do research on health issues and provide education to the public. It was anticipated maintenance of this centralized data repository would cost providers and payers $0.02 per claim.

In October, 1995, CHMIS released Request for Proposals to companies that were interested in contracting as the centralized data repository. When bids were received, however, the projected cost per claim shot up to $0.18 per claim. The CHMIS Governing Board realized this would not be acceptable.

As a result, the Governing Board called a special task force to redesign the CHMIS process. The task force recommended the CHMIS mission could still be accomplished, but in a voluntary environment rather than through mandates contained in the law. The Governing Board agreed and requested the 1996 Legislature delay the start of CHMIS until July 1, 1997. The Legislature passed the request.

The task force suggested CHMIS should concentrate on two key roles. The first—standardize the electronic claim submission process—would help reduce administrative costs to the health system. The second role—utilize existing data bases to produce various health information and research—would fulfill CHMIS' education and research role.

This concept was given a boost by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This federal law requires the Secretary of Health and Human Services to develop national standards for the submission of nine different health care transactions. CHMIS would like to use this federal mandate as a starting point and provide further clarification for providers and payers operating in Iowa.

CHMIS was counting on the data repository to provide enough revenue to make it self-sufficient. With this concept out the window, CHMIS has now requested about $300,000 in state funds to support its efforts. A denial by the legislature would put CHMIS' future in jeopardy.

What's expected on July 1, 1997?

As mentioned previously, the CHMIS Governing Board would like to carry out its mission in a voluntary environment. There is no intention to establish certified networks. While the current law states physicians must submit insurance claims electronically starting July 1, 1997, this will not be enforced. Instead, CHMIS will encourage physicians, other health professionals and all payers to implement national and state standards to submit health transactions electronically.

The Iowa Medical Society encourages physicians to submit insurance claims electronically. CHMIS will follow the timetable contained in HIPAA to implement electronic claim submission standards. Those physicians not prepared to send claims electronically need not worry at this time, but should keep current on CHMIS developments.

An issue of "Deadline News" will be sent to all IMS members in June. This newsletter will update you on the legislature's decision to fund CHMIS and provide clarification on what is expected of Iowa's physicians. IM

Physicians will not be required to submit insurance claims electronically starting July 1, 1997 as required in the current CHMIS law. CHMIS must obtain funding by the 1997 Iowa Legislature or its future is in jeopardy.

For more information, call Ed Whitver, director, department of administration, 515/223-1401 or 800/747-3070.

Practice Management

News at a glance

Improper hospice care referrals will prompt a crackdown from HCFA, according to Kiplinger Washington *editors. HCFA will keep a closer eye on doctor referrals to be sure only patients likely to live six months or less go to a hospice. Doctors will get clearer instructions from HCFA on what is acceptable.*

Mental illness is covered by the Americans with Disabilities Act. When hiring, you can't discriminate against someone who has had problems with depression, anxiety, etc. The best advice is to make accommodations for employees who have emotional problems—different hours, more privacy or other such steps.

CLIA requirement misconception clarified

In response to correspondence from physician offices, the Iowa Department of Inspections and Appeals is correcting a misconception about CLIA requirements. Some physician office staff believe if their office only performs waived and/or provider-performed microscopy, it is not required to meet CLIA requirements. This information is incorrect.

If an entity (including a physician office laboratory) performs a laboratory test for the purposes of diagnosis, screening or treatment, it is required to register with the CLIA program and possess a current CLIA certificate. The four types of CLIA certificates are: certificate of waiver, certificate of provider-performed microscopy, certificate or certificate of accreditation.

Although a laboratory with a certificate of waiver or a certificate of provider-performed microscopy is not routinely inspected, it is expected to have trained staff, follow manufacturer guidelines, complete renewal forms and pay applicable fees. Also, if the physician practice moves, closes or is sold and there is an associated CLIA certificate, the laboratory must notify the Iowa Department of Inspections and Appeals office in writing no later than 30 days after the change occurs.

For additional information, contact Nancy Ruzicka at the Iowa Department of Inspections and Appeals, 515/281-3765.

Privacy/security of electronic records

Computerized medical records are vulnerable to misuse and abuse, but few people recognize the extent of the problem and little is being done to improve the security of personal files, according to a National Research Council panel.

The panel examined electronic medical records because they are becoming the norm in health care and efforts are growing to link health records kept in different places.

"Efforts must focus on finding ways to maintain privacy rather than opposing the use of information technology in health care," says Dr. Paul Clayton, medical information specialist and chair of the panel. IM

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Practical guidance on the creation/implementation of an effective compliance program to reduce your risks if audited or reviewed. Instructors: Barb Cannon and Barb Pierce, IMS staff.

Midwest Medical Insurance Company Focus on Risk Management

Malpractice: the hidden, emotional costs

Negligence. Malpractice. Lawsuit. These are all very stressful words for physicians. In today's world, every physician is aware of the possibility of being sued for malpractice. A study of physicians' emotional reactions to malpractice litigation by Sara Charles, MD showed over half of the physicians experienced anger, inner tension, depressed mood, frustration, irritability and insomnia. Over half also felt that they and their families had suffered emotionally. These are the hidden costs of malpractice.

Being sued for malpractice is often described as a traumatic life experience. The AMA Board of Trustees has stated that, "The biggest cost of suits brought under the malpractice system is the emotional injury that a physician experiences when he or she believes that he or she had done the best possible under difficult circumstances." While you cannot completely avoid the emotional reactions a malpractice claim elicits, there are ways to cope.

One way is to realize you are not alone. Although statistics tell us thousands of physicians nationwide will be sued this year, many of the physicians in Dr Charles' study felt alone in their ordeal. It is important to remember other physicians have gone through what you may be experiencing. You can benefit from sharing the emotional fallout with a colleague who has been there and survived.

Recognizing the benefits of collegial support, MMIC in a joint effort with IMS is developing the Physician Litigation Support Program. The purpose of the program is to provide information and support to physicians experiencing stress related to the litigation process. Volunteer physicians who have been through the litigation process will be available for one-on-one, confidential support of their colleagues. Information about the litigation process and the emotional response will also be available. Physician volunteers are needed for this program.

For more information contact Lori Atkinson, MMIC risk management supervisor, Midwest Medical Insurance Company, West Des Moines Office, PO Box 65790, West Des Moines, Iowa 50265; 800/798-9870 or 515/223-1482.



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Iowa physicians, physicians' spouses, professional organizations, community groups, churches, businesses and others donated $80,000 worth of Baby Think It Over dolls to schools across Iowa.

This list of donors reflects the effort Iowans have taken to educate young people about the realities of parenting. IMS and IMSA extend their deepest appreciation to all the donors who contributed to the Baby Think It Over project, to all the educators who have implemented the program into their curriculum and to the students who are learning what it's like to parent an infant.

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The 11th Commandment:

Thou shalt create a compliance program

Many physicians think: "I cannot afford a compliance plan. Besides, they are only for big organizations!" They are wrong. These authors address that misconception and answer other frequently asked questions about compliance plans.

Michael Reiling
David Glaser
Michael Reiling is a senior associate with Partners Consulting Group, Ltd., a Minneapolis-based consulting firm specializing in revenue and compliance issues. David Glaser is a health care attorney with Fredrikson and Byron, P.A., Minneapolis.

Complying with the many conflicting rules confronting a medical practice can be expensive and daunting. Many practitioners would, quite understandably, prefer to focus on providing medical care rather than compliance and coding. But, increased scrutiny from governmental and private payers makes it very risky for a physician to fully delegate responsibility for coding and billing. It is important to remember that coding is a language; and unless all parties understand the words spoken, serious problems may result. Because of this, physicians should develop programs to ensure they are in compliance with the many complex and changing regulations governing health care. In particular, providers must focus on accurately billing and documenting clinical services to avoid charges of fraud and abuse. Here are some answers to the most frequently asked questions about compliance plans.

Since many elements of a successful plan are tangible, you need to tailor the plan to fit your practice.

Q. Is it really necessary for me to have a compliance plan?

A. Yes. All health care organizations, including solo practitioners, should adopt some type of compliance plan. In small organizations, the plan will be simpler and less formal; but in the eyes of the government everyone must make a tangible effort to comply with the law. As the number of government agents and private companies who scrutinize health care providers grows, so does the likelihood that you will be faced with an inquiry or investigation.

Agents and prosecuting attorneys investigating a provider have a great deal of discretion to determine whether to pursue a case. A key factor in the decision is usually whether the provider and staff are making every reasonable effort to comply with the law. Since the penalties for billing errors can include jail time or civil false claim penalties with a minimum fine of $5,000 per claim plus three times the amount of any improper payments, everything you can do to convince the government of your good intent is worthwhile.

Remember, a government agent can interview your employees (or perhaps ex-employ-

ee) to determine the steps you have taken to comply with pertinent laws. To answer the questions, all employees need to be educated on the policies and procedures you have established. If you have what the government considers to be an effective compliance plan, it is much less likely that the government will seek extreme penalties if problems are found.

Q. What is a compliance plan?

A. Perhaps the most important component of a compliance plan is a method to detect, correct and prevent billing improprieties. While documents are part of a compliance plan, it is primarily an attitude and approach to doing business. When an investigator tries to determine whether you have a compliance plan, the investigator may review your policies, but the focus of the investigation will be your actual behavior. The agent will conduct interviews with your employees to determine whether they believe the practice has made concrete efforts to comply with the law. By establishing a compliance plan, you are creating a method to demonstrate both intentions and required behaviors.

Q. What elements are necessary to have as part of my plan?

A. The federal sentencing guidelines for organizations describe certain key elements a compliance plan must have before the government will consider it effective. At minimum, there must be:

1. An individual with substantial authority designated as the Compliance Officer.

2. Standards and procedures reasonably capable of reducing the likelihood of any criminal conduct.

3. No authority given to any individual with a history of improper activities.

4. A training program designed and implemented to explain the practice's policies, including the fact that all employees are required to comply with every applicable law.

5. A method to monitor and audit the practice's operations to ensure the practice complies with all laws.

6. A way to fully investigate any violation of the law. The Compliance Officer must immediately notify both administration and legal counsel upon the discovery of any violation of the law, or a significant violation of the practice's policy.

7. A consistent policy for disciplinary action against any employee including physicians who violate the law or any policy related to the compliance plan must be in place and enforced.

The sentencing guidelines state that when a practice has a compliance plan, criminal penalties may be reduced by up to 95%. More important, an effective compliance plan makes it far less likely that the practice will violate the law in the first place because problems will be detected and corrected. This assumes the plan is in force, not just a document sitting on a shelf.

Q. How do I begin ?

A. The first step in implementing a compliance plan is to form a work group composed of internal and external experts. Legal counsel is vital because it may be possible to protect much of your activities under the attorney/client privilege. However, if you act without the proper protections, it is possible the government will be able to use your own investigation against you.

After you have contacted counsel, administration should adopt a resolution to formally develop and implement a compliance plan.

Merely buying a book and distributing it to employees does not demonstrate sufficient commitment to compliance.

Administration should appoint a high-level officer, someone with substantial authority over the entire practice, to act as a compliance officer and oversee the implementation of the plan.

A strong internal commitment to compliance is the best way to convince an investigator of your sincerity.

Next, the practice should work with legal counsel with expertise in health care regulation to review its policies and procedures to determine whether they sufficiently reduce the likelihood that the practice or one of its employees is in violation of any law. For example, there must be policies explaining key laws in terms the average employee can understand and policies explaining how an employee should react if he or she suspects the law has been violated. The most important part of this review is a legal audit designed to assess the practice's compliance with the laws most likely to cause trouble.

Concurrently, the practice should launch an education campaign to ensure that every employee, including physicians and staff, receives appropriate training about the Medicare billing rules and other laws. As part of the education program, every employee, including physicians, must be required to attend sessions describing the most important rules. At the end of each session, employees should be required to certify they have attended the program. In addition, written materials should be distributed. Employees, including physicians, must be required to read these materials.

The other key piece of a compliance plan is a detailed coding review tailored to specialty and location. The review must include confirmation that:

- The CPT codes submitted accurately reflect the services provided;
- Adequate documentation exists to support services reported;
- Services are bundled (or unbundled) properly;
- Modifiers are used as appropriate, etc.

Large practices may have sufficient staff to conduct much of this audit internally, while smaller practices may need to rely exclusively on outside experts. In either case, it is very important that you incorporate an audit by an external reviewer into the process. The government is very skeptical of purely internal programs. Given the complexity of the billing rules, it is quite likely that even the most careful providers will still make mistakes. Using an outside consultant may also provide some additional assurance to the government that you are taking every step possible to comply with the law. The coding audit should be linked to the educational campaign designed to confirm that all physicians and staff are familiar with the key rules.

An external review need not be costly. In a smaller practice, a periodic review of as few as 10 charts will provide a physician with an argument that there is a monitoring program in place. Also, the Iowa Medical Society may be able to provide you assistance.

Q. Can I do a compliance plan on my own?

A. A great deal of the work can, and should, be done internally, but some parts of the plan will require outside assistance. A strong internal commitment to compliance is the best way to convince an investigator of your sincerity. In fact, it would be a mistake to rely too heavily on outside assistance. For your plan to be successful, your staff must at least know enough about the key rules to know when they need to seek advice. While much of the work will be internal, it is vital that you work with your legal counsel and with outside billing experts.

First, there are legal issues involved in developing the compliance plan and mistakes can be costly. For example, developing a plan involves the attorney/client privilege,

employment issues and fundamental questions about how to respond to the billing problems you uncover. Second, the government expects outside oversight of your compliance activities. The government is often cynical and believes internal programs are more likely to result in whitewashed investigations. The government is more likely to believe your mistake was an innocent one if the government is convinced you took every reasonable step to be in compliance. Seeking outside assistance is strong evidence of your good faith. Finally, it's what you don't know that can hurt you most. Many billing mistakes are the result of ignorance, not malice. Obtaining assistance decreases the likelihood that you will miss a key issue or rule.

Q. Are ready-made compliance plans available?

A. Several national health care organizations are in the process of developing model compliance plans. At this time, it is impossible to predict what form these plans will take. In addition, to capitalize on the newfound popularity of compliance plans, many companies are offering "off-the-shelf" plans. While merely adopting a plan written by someone else may be appealing, it is of questionable value. Remember, a compliance plan is not a book; it is a process and an attitude. In the eyes of the government, merely buying a book and distributing it to employees does not demonstrate a sufficient commitment to compliance.

Moreover, since many elements of a successful plan are intangible, you need to tailor the plan to fit your practice. Perhaps the only thing worse than failing to have a compliance plan is adopting a compliance plan but failing to implement it successfully. An effective plan will require employees at all levels of the practice to understand the need for the plan and to commit to work at compliance. Many employees do not understand that making a simple billing mistake may result in extreme penalties. An effective plan requires a training process so that all employees recognize the regulated nature of the industry.

If an investigator sees your practice going through the motions of forming a plan without doing it successfully, the investigator may conclude your efforts were inadequate. To be successful, a compliance plan must fit the size, culture and style of your practice and be workable.

Q. What will it cost to create a plan?

A. The costs will depend on the size of your organization and your current compliance efforts. There will be costs in internal staff time and expenses for outside expertise. In smaller practices, proportionately fewer resources must be focused on compliance. You should remember, however, that money talks. One way the government will evaluate your commitment to compliance is by reviewing the priority it receives in your budget.

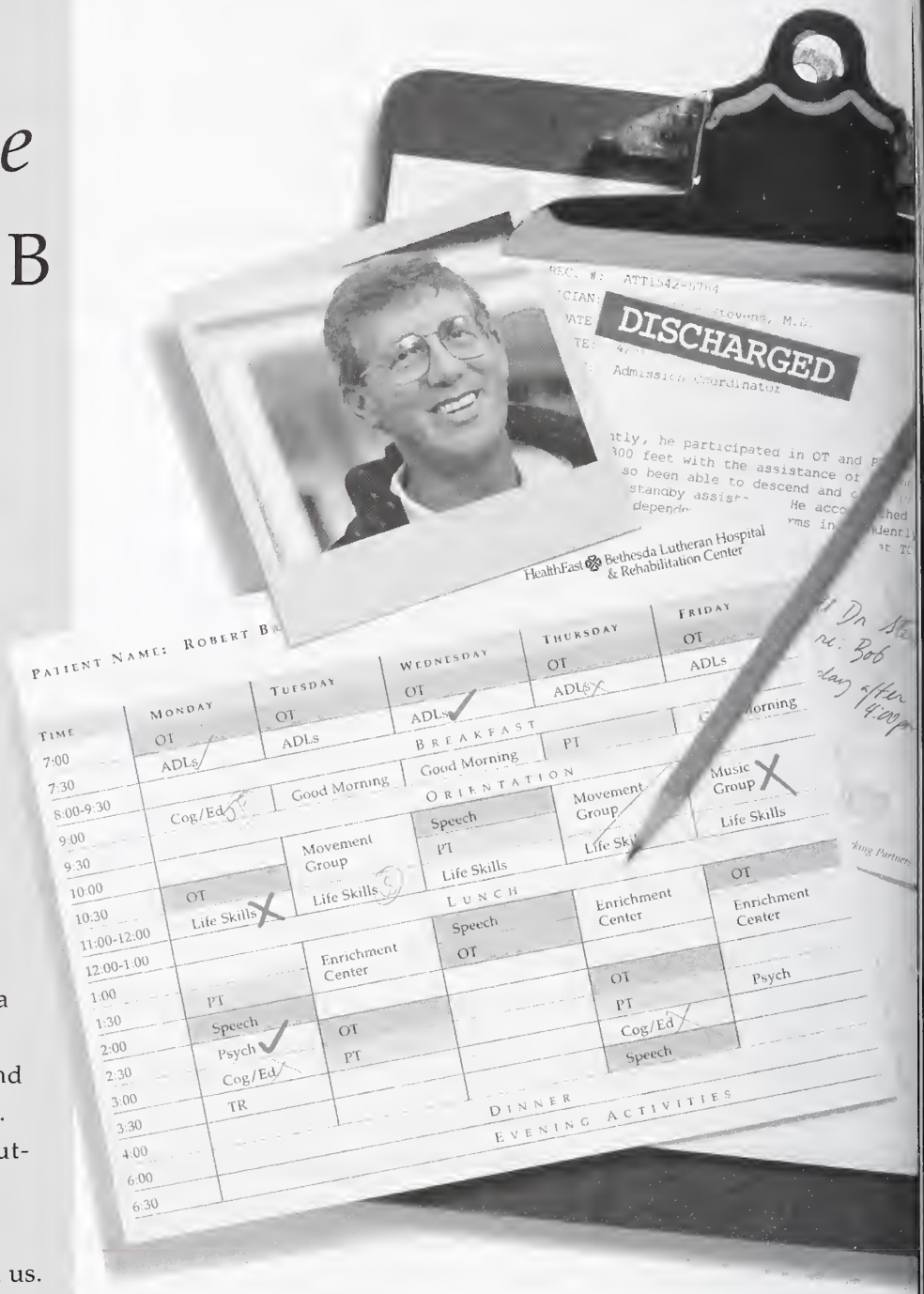
When evaluating the costs of developing a compliance plan, it is useful to compare them to the cost of doing nothing. The price of a plan pales when compared with the costs of defense in an investigation or fines for false claims. The legal fees of responding to one significant Medicare overpayment or investigation may exceed the cost of developing a compliance plan. In short, a good compliance plan can be cost effective. IM

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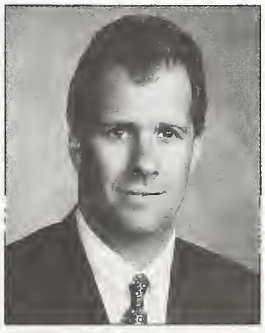
In the past it was standard procedure to transfer all assets to one's spouse or establish a trust for the children to protect those assets. The transfer of assets to a spouse has been ruled ineffective by some courts since the spouse is merely holding the property for the debtor spouse as a trustee. In addition, such a strategy creates potential problems to the owner, as in the case of a divorce.

Transferring assets to a trust for the benefit of the children works, but if rights over the property are maintained, assets are generally not protected from creditors. Protection is most likely to be accomplished only if all ties to the trust property are completely severed. Transferring the assets must have been made prior to a lawsuit to avoid fraudulent conveyance.

A more effective technique is the use of family limited partnership (FLP). This is an entity created to own certain assets or property. Gifts of the limited partnership interest are made to children, grandchildren or trusts for their benefit. The grantor maintains control of the FLP as the general partner.

In the event of a lawsuit, creditors are generally only entitled to the debtor's interest in the partnership, but not the actual assets owned by the partnership. Since creditors are generally not interested in being partners with the debtor's children or grandchildren, it puts the debtor in a much better negotiating posture.

Some recent strategies have utilized offshore trusts, therefore removing the trust assets from the whims of the domestic legal system. In addition to giving protection from creditors, foreign trusts provide benefits such as probate avoidance and confidentiality. This strategy can be effective, but certainly requires the services of an attorney and planner knowledgeable in the use of offshore trusts.



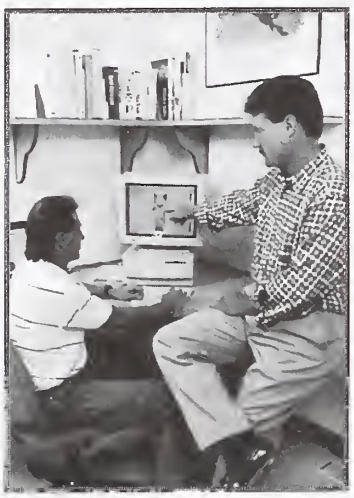
JERRY FOSTER

In addition to the protection of the assets, an FLP also provides compelling estate and gift tax savings. The gift and estate tax advantages are achieved through gifts of limited partnership interests made to the children or grandchildren. Even though the grantor retains control as the general partner of the FLP, the transferred interest will not be included in the estate of the grantor. The use of an FLP is a well-suited planning strategy that can help protect assets while you are alive and preserve assets at your death. These benefits make the FLP worth your time to research. IM

A family limited partnership also provides compelling estate and gift tax savings.

Jerry Foster is the founder and president of Foster Capital Management, a fee-based financial advisory firm endorsed by the Iowa Medical Society. Mr. Foster can be reached at 1-800/798-1012.

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The Journal
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Alzheimer's disease: new horizons in diagnosis and treatment

● *Lynn Rankin, MD*

In last October's issue of *Iowa Medicine*, Dr. Gerald Jogerst reviewed the diagnostic features of Alzheimer's dementia and focused on therapy with tacrine hydrochloride (Cognex). He provided practical guidelines for the use of Cognex but stressed that Cognex is not curative and only helps a subset of patients with mild-to-moderate stage Alzheimer's disease. Cognex will remain the first agent approved for the treatment of Alzheimer's disease, but is no longer the only agent available.

We are in the midst of an explosion in research on all facets of Alzheimer's dementia. While no one has yet offered a complete explanation of the pathogenesis of the disease, advances in our understanding of the pathology, neurochemistry and genetics of the disease are leading to discovery of new biologic markers, genetic markers of susceptibility, means of presymptomatic detection and pre- and post-symptomatic therapies.

The hallmark pathologic features of Alzheimer's disease are the "senile" plaques and neurofibrillary tangles in the temporoparietal cortex. The plaques contain beta-amyloid, a fragment of the amyloid precursor protein. The tangles are composed of the microtubule binding protein, tau. This knowledge has led to development of assays for tau and beta-amyloid (Aß 42) in CSF which are now commercially available. These tools cannot stand alone in diagnosis but potentially can improve the accuracy of clinical diagnosis to above the 85% range and may allow us to diagnose and initiate treatment sooner.

Genetic marker—apolipoprotein E

Apolipoprotein E (APOE) is an exciting new marker of genetic susceptibility. APOE is a normal cholesterol carrier protein that has been found in the beta-amyloid plaques in affected individuals. The APOE gene is located on chromosome 19 and has 3 alleles, 2, 3 and 4. The APOE e_4 genotype is strongly associated with late onset Alzheimer's disease (Roses). An individual who is homozygous for e_4 has a 93% chance of developing the disease. This represents an over eightfold increased risk while those heterozygous for e_4 have a two-to-three-fold increased risk (Corder). But, lack of e_4 does not guarantee against development of the disease as 50% of Alzheimer's patients lack e_4. Thus, clearly other undetermined factors are at work.

A fascinating study published in the March 21, 1996 issue of *The New England Journal of Medicine* revealed that cognitively normal persons age 50-65 who are homozygous for e_4 already had reduced glucose metabolism in the typical Alzheimer distribution on PET scans (Reiman). Not only may presymptomatic detection be possible, the findings of this study suggest a method for measuring success of early therapeutic intervention. The e_2 allele appears to be protective, a finding that ultimately may end up having greater significance than the e_4 finding. As with the new diagnostic marker assays, the APOE test should only be performed with full knowledge of its limitations.

Role of estrogen

A growing body of evidence suggests neurotrophic and neuroprotective effects of estrogen. Estrogen promotes the growth of cholinergic neurons and has neuroprotective effects in ovariectomized rats (Schneider). Premarin-treated cortical neurons exhibit marked neuronal outgrowth in tissue cultures compared to controls (Brinton). Estrogen also stimulates the metabolism of the amyloid precursor protein.

A possible explanation for the decreased incidence of Alzheimer's disease in men is

The IMS Education Fund has designated this article as the Henry Albert Presentation Award for May–June 1997.

Lynn Rankin, MD
Dr. Rankin practices neurology with Integra Health in Des Moines.

Alzheimer's disease: new horizons in diagnosis and treatment

continued

the fact that testosterone levels and estrogen (converted from testosterone) levels remain constant in males well into the eighth decade of life. These lines of rationale led to recent studies of the effect of estrogen on the development and on the course of Alzheimer's disease.

Estrogen for prevention

In a study reported in *Lancet* earlier this year (Tang), 1124 neurologically intact postmenopausal women were followed for one to five years. Thirteen percent reported past or current estrogen use. A much smaller percentage of the estrogen users developed Alzheimer's disease than the nonusers. Even after controlling for variables such as education, race and APOE genotype, the risk reduction was 60%. The risk reduction was greatest for those who had used estrogen for over one year. Age at onset of Alzheimer's disease was later for those who had used estrogen.

A large national prospective study has just been launched to further look at the impact of estrogen on development of Alzheimer's disease. The Women's Health Initiative Memory Study is being funded by Wyeth-Ayerst Laboratories, the manufacturer of Premarin and Prempro. Nationally, over 8000 women age 65 and over will be followed for a minimum of six years. Study centers are located in Iowa City and Des Moines. Call 800/348-4692 for more information.

Estrogen as treatment

A side analysis of the large, randomized and blinded tacrine (Cognex) study revealed that women who took tacrine plus estrogen improved more than those on tacrine alone or placebo (Schneider). In a population-based study, mortality related to Alzheimer's disease was reduced in estrogen users (Paganini-Hill). In a prospective study sponsored by the Alzheimer's Disease Cooperative Study Unit, women with probable Alzheimer's disease will be randomly assigned to one of two estrogen doses or placebo and followed for one year to determine the effect of estrogen on disease progression. The results of this study along with the eventual results of the Women's Health Initiative Memory Study will greatly aid us in our recommendations regarding estrogen for patients and for those at risk.

Role of NSAIDs

In addition to the pathological findings of amyloid plaques and neurofibrillary tangles in Alzheimer's disease, more than 40 proteins are found in the same region. The proteins are characteristic of an inflammatory response and include complement proteins, cytokines, acute phase reactants and proteases, and protease inhibitors. This finding of neuroinflammatory changes on Alzheimer's pathology plus the finding of a lower frequency of Alzheimer's disease in patients with rheumatoid arthritis led to further studies of a possible ameliorating effect of NSAIDs.

A recent meta-analysis of 17 epidemiologic studies provided very encouraging results, suggesting a protective effect of NSAIDs on development of Alzheimer's disease (McGeer). Ten case-control studies and seven population-based studies were reviewed which used arthritis or anti-inflammatory medication as possible risk factors for Alzheimer's disease. Group and subgroup analysis yielded highly significant results of a negative association as shown by the following odds ratios: arthritis studies 0.556, NSAID studies 0.496 and steroid studies 0.656.

The Baltimore aging study found that the longer the duration of exposure to NSAIDs and the more distant the exposure, the lower the risk for development of Alzheimer's disease (Corrada). Aspirin alone was not found to be protective. The only controlled prospective trial looked at indomethacin versus placebo treatment of 28 affected individuals over a six-month period (Rogers, J.). Indocin-treated patients improved while placebo patients worsened. Further prospective studies are needed to address the degree of treatment effect, the type of NSAID, the dose and duration.

Cholinergic agents

Many of the new agents under study are designed to augment acetylcholine, e.g., the acetylcholine esterase (AChE) inhibitors and the ACh precursors. As mentioned earlier, the first AChE inhibitor to gain FDA approval

was Cognex (tacrine), while the second was Aricept (donepezil, Pfizer Labs). Donepezil was released in January 1997. By virtue of being a selective central AChE inhibitor, it possesses the ability to improve performance and learning of memory tasks while lacking significant systemic side effects. Three-to-six-month studies have demonstrated dose-related cognitive improvement in those with mild to moderate Alzheimer's disease (Rogers).

In an effort to minimize GI side effects, it is recommended that a bedtime dose of 5 mg be prescribed for one month before titration up to 10 mg nightly. The beneficial effects of the drug appear to continue over two years of treatment but abate within six weeks of discontinuation. See Table 1 for a comparison of the pharmacologic properties of donepezil and tacrine.

Other AChE inhibitors in late stages of testing include Synapton (Forest Labs), Exelon (Sandoz) and metrifonate (Bayer). Citicoline is an ACh precursor that appears to improve memory in the elderly but has yet to be tested on Alzheimer's patients.

The glycine agonist, d-cycloserine; the antioxidant, idebenone; histamine H_2 blockers; and the monoamine oxidase-B inhibitor, selegiline, are a few of the other agents under investigation.

Summary

We are in the midst of an explosion in research in Alzheimer's disease. Advances in our scientific understanding of genetic factors and pathogenesis are leading to enhanced diagnostic capabilities and new presymptomatic and symptomatic therapies. Estrogen therapy in postmenopausal females and NSAIDs show early promise, while AChE inhibitors keep getting better. Armed with knowledge and new diagnostic and therapeutic tools, we can finally begin to fight this devastating disease.

Bibliography

A complete bibliography is available by contacting the author or editors of *Iowa Medicine*. IM

TABLE 1 (Doraiswamy)
COMPARATIVE PHARMACOLOGY OF DONEPEZIL AND TACRINE

Property	Donepezil	Tacrine
Chemical class	Piperidine	Acridine
Mechanism of ChEI	Reversible	Reversible
Selectivity for neural vs. nonneural tissue at relevant doses	Selective	Nonselective
Potency (IC50) for AChEI	Relatively higher	Relatively lower
Dose-plasma level relationship	Linear	Nonlinear, variable
t½ at therapeutic doses	About 70 hours	1.4–3.6 hours
Metabolism	Renal and hepatic	Hepatic
Effect of food or time of day	No significant effect	Reduces absorption by 30%
Renal disease*	No effect on clearance	No effect on clearance
Hepatic disease*	No effect on clearance	Likely to reduce clearance
Dose strengths	5 and 10 mg	10, 20, 30 and 40 mg
Dosing	Once daily at bedtime, no effect on food intake	q.i.d., 1 hour before meals
Effective doses	10 mg≥5 mg>placebo*	160 mg>120 mg>80 mg>40 mg=placebo*
Dropout rates due to side effects in pivotal trials	Much lower, 5%–13% (10 mg>5 mg=placebo)	Higher (up to 58% based on study design)
Hepatic (ALT) monitoring	Not required	Required

*Some of these comparisons should be considered preliminary.

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Spring: a time for renewal

This morning I was awakened by the singing of birds, the songs of robins and cardinals. What a relief these harbingers of spring are over the cold winds of winter trying to invade our homes. Then, to look out the window to see the grass turning green and the flower garden awakening with new shoots and a few early blossoms . . . ah! Better than ice and snow.

Spring is the time for renewal; renewal of the purposes we have in our day-to-day endeavors. Much of our daily life during the winter months becomes quite humdrum for many of us. Of course there are those hearty souls who engage in winter sports, but for most of us it is much the same every day; some do more reading, others become "couch potatoes"; others go about their daily tasks without much variety.

Fortunately in our profession we have new challenges every day. Whatever our specialty, be it general medicine or a highly specialized surgical practice, no day can be considered boring. So, why do I extoll springtime as a new horizon, a period of renewal?

There is a challenge for each physieian this spring and a continuation of challenges to our profession. By the time this issue of *Iowa Medicine* is published our medical society will have had our Annual Meeting where delivery of health care issues is diseussed. The pressures of interference by extraprofessional forces, managed care, governmental edicts, liability risks and other aspects of our relationships with our patients continue. We are faced with responsibilities to society as a whole as well as to our individual patients. Violence, child abuse, drug and alcohol abuse and compulsive gambling loom before us as our responsibilities, too.

In addition we owe it to our patients, as well as ourselves, to be involved in meaningful continuing medical education . . . not to attend courses because of an ideal location just to get credit hours to fulfill licensure requirements.

The IMS House of Delegates has met for another year. A new leadership is at the helm and the challenges and responsibilities are great. The help and encouragement of each member is paramount to a successful new year at the IMS. We should pledge that support.

We owe it to our patients, as well as ourselves, to be involved in meaningful continuing medical education.

The editorial staff of *Iowa Medicine* accepts its responsibility to disseminate pertinent information to members of our society. We welcome comments from our readers. It is our mission to serve and that we will do, as we look forward to a new year. IM



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Continuing education on health policy

How are physicians educated about health policy? Most individuals enter medical training with little specific knowledge about the organization of health care services and financing, public health programs or medical-legal matters. In the undergraduate medical curriculum there is basic exposure to these issues.

Especially during recent years, most medical schools have expanded their teaching related to population-based preventive medicine programs, public health priorities and health care financing. During the residency or fellowship experience, many physicians obtain additional specialty-oriented insight into policy. These insights may include the cost-effectiveness of organ or system interventions. For example, a great deal of attention has been focused on the justification for broadly used screening or diagnostic procedures such as mammography and costly interventions such as coronary bypass procedures.

Physicians in practice become informed about emerging health policy issues through their specialty organizations and other membership organizations, including state medical societies. Abundant reading materials are available through these groups. Scientifically-constructed studies and opinion pieces are widely published in journals with broad readership, including the *Journal of the American Medical Association* and the *New England Journal of Medicine*.

For many physicians, however, the issues are most real if there is an implication for practice within their own community. The rationale for undertaking a procedure is more likely to be examined in the context of a peer review activity conducted in the community hospital, than made relevant by a study or statement published in the national medical media. Ultimately, defensible peer review activities should have objective studies as the basis for making decisions and it becomes the responsibility of physician leaders to translate or interpret studies and statements so they can inform local decisions.

For many physicians, however, the issues are most real if there is an implication for practice within their own community.

An increasing number of organized continuing medical education workshops and conferences deliberately plan sessions devoted to discussions of health policy issues. While some physicians may view such sessions as less relevant than "how to" topics, they may ultimately be most crucial in shaping practice.

We can all profit by reflecting on how we learn about and incorporate policy issues into our professional work. The active pursuit of continuing education in this field is essential for the contemporary practicing physician. IM



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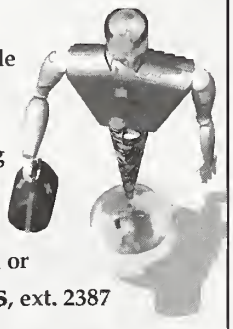
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Iowa Medicine

JOURNAL OF THE IOWA MEDICAL SOCIETY | JULY–AUGUST 1997

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1997-98 IMS PRESIDENT



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PHYSICIAN COMMUNITY SERVICE AWARD WINNER



TOM FOLEY, MD
MERIT AWARD WINNER

Alternative medicine



Read what an Iowa City physician has to say about the role of spirituality and mind-body therapies in healing . . . page 232

IMS member physicians and nonmember physicians share their opinions in a comprehensive survey
See page 235 for all the results

New Iowa law and medical records *Check out the latest from the new IMS staff attorney, page 239*

It's easy to get involved in setting IMS policy *page 237 has the details*

STACKS

Legislative voting records on tort reform and point-of-service bills *page 225*

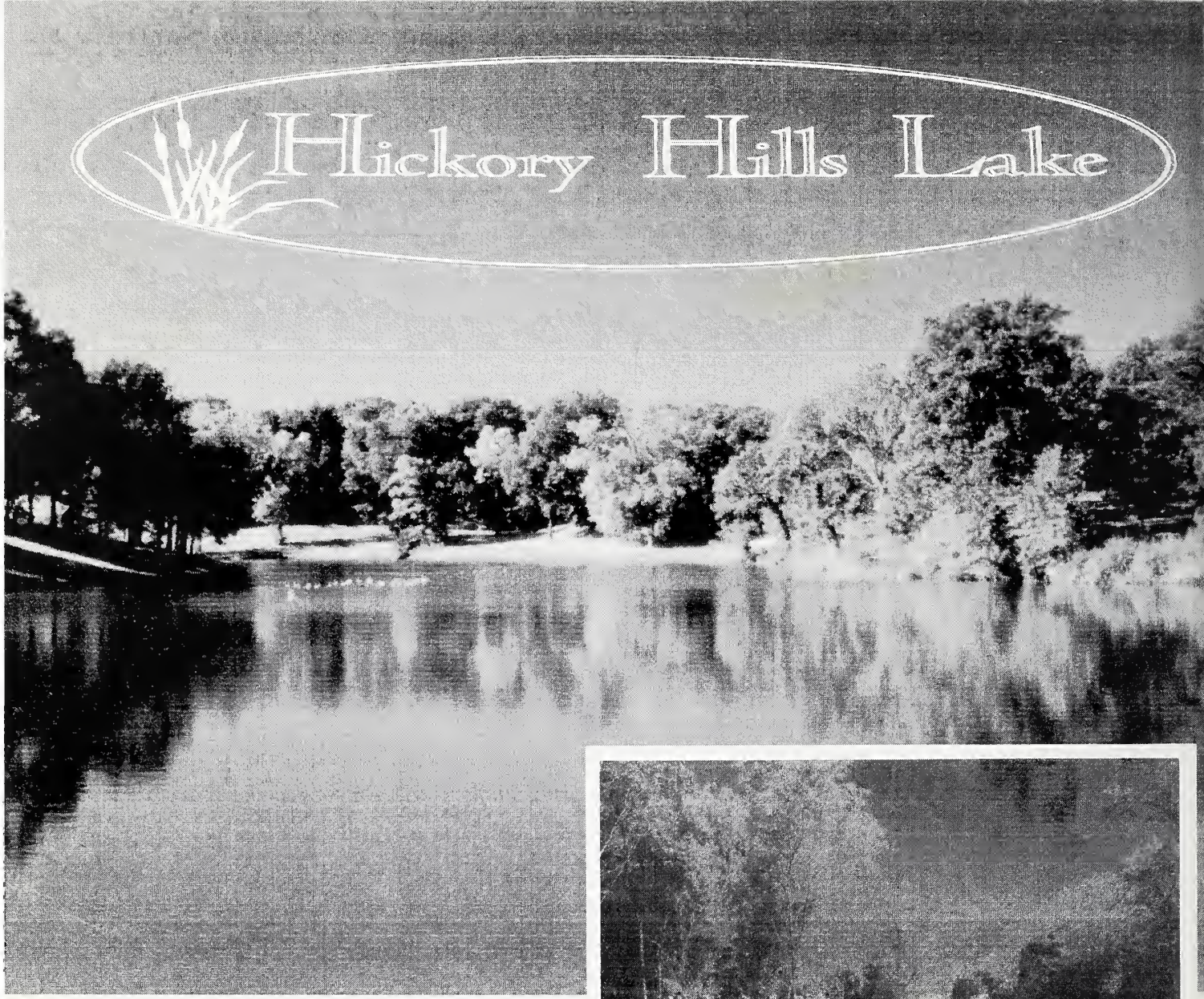
Is there hope that SIDS can be prevented?
See page 243 for the Iowa perspective

STACKS



Find out what you missed at the IMS House of Delegates and Annual Meeting in April
See the center insert

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IMS Seminars

September/October 1997

Office Communication Skills ★

Instructor: Kathryn Barrington, Business Resource Center, Inc.

Designed for all members of the office team, this seminar provides an intense, practical application of language skills, building people-to-people communication skills and improving your ability to prevent communication problems. The focus will be on handling difficult situations that occur in the medical office everyday as we interact with families, patients, vendors, physicians and coworkers.

Seminar time is 9:00 a.m. to 4:00 p.m.

DATE	SITE
Sept. 16	Taylor Room, IMS Headquarters West Des Moines
Sept. 17	Professional Development Center, St. Ambrose, Davenport

Medical Terminology

Instructor: Barbara Pierce, Iowa Medical Society

This full-day seminar is an overview of medical terminology with an emphasis on building a working medical vocabulary to assist in coding, completing insurance claim forms and maintaining charts. The seminar includes basic terminology structure, component parts, roots, suffixes, prefixes and medical term origins.

Seminar time is 9:00 a.m. to 4:00 p.m.

DATE	SITE
Sept. 9	Marron Classroom, Mercy Hospital Cedar Rapids
Oct. 15	Taylor Room, IMS Headquarters West Des Moines

Health Insurance Overview ★

Instructor: Cynthia Swanson, Seim, Johnson, Sestak & Quist

This seminar is an overview of the basics of health insurance including insurance principles, the evolving delivery systems, contract and benefit highlights, insurance claim filing systems, tips for troubleshooting claim payment problems and post-payment monitoring systems.

Seminar time is 10:00 a.m. to 2:00 p.m.

DATE	SITE
Oct. 7	West Campus #7 North Iowa Mercy Health Center, Mason City
Oct. 28	Marron Classroom, Mercy Hospital Cedar Rapids

Resource Management ★

Instructors from Vroman, McGowen, Hurst, Clark & Smith, PC

This workshop is designed to provide you with basic information about accounting, tax and human resource issues to assist a successful practice. The session will feature financial aspects of your office that include: basic accounting transactions, reading and understanding financial statements, payroll tax reporting, cost controls and planning for growth. Human resource issues will include: ADA, FMLA, interviewing, performance measures and compensation.

Seminar time is 9:00 a.m. to 4:00 p.m.

DATE	SITE
Oct. 2	West Campus #5, North Iowa Mercy Medical Center, Mason City

ICD•9•CM Coding ★

Instructor: Mary Pat Wohlford-Wessels, University of Osteopathic Medicine and Health Sciences

This seminar will offer something for coders with all levels of experience. It will cover the basics of the ICD•9•CM coding system. Emphasis will be on using the system effectively and appropriately. Correct use of V-codes will be included. Tips for facilitating insurance claim processing will be discussed. Please bring an ICD-9 book.

Seminar time is 9:00 a.m. to 4:00 p.m.

DATE	SITE
Sept. 24	Taylor Room, IMS Headquarters West Des Moines
Oct. 29	Room 1, St. Luke's Regional Medical Center Sioux City

Office Safety and Compliance Issues ★

Instructor: Barbara Cannon, Iowa Medical Society

A different view of office safety that is sure to catch everyone's attention. You will appreciate this review of suggested and required safety programs for physician offices.

Seminar time is 10:00 a.m. to 2:00 p.m.

DATE	SITE
Sept. 10	West Campus #7 North Iowa Mercy Medical Center, Mason City

★ These seminars are part of the IMS Medical Business Specialist (MBS) Certificate Program.

REGISTRATION FORM

Complete this form and mail it along with your check or money order to:
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NAME(S) _____

OFFICE/CLINIC _____

ADDRESS _____

TELEPHONE _____ FAX _____

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Are you in the MBS Certificate Program? YES NO

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Office Communication Skills	
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ICD•9•CM Coding	
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❑ Oct. 29 • Sioux City	$99/$198
❑ Nov. 18 • Davenport	$99/$198
Resource Management	
❑ October 2 • Mason City	$99/$198
Office Safety & Compliance Issues	
❑ Sept. 10 • Mason City	$49/$98

**** If you or your physician is an IMS member you pay the first price; nonmembers pay the second amount.***

IMS *DEADLINE* news

July-August, 1997

Late-breaking news of interest to Iowa physicians

•**THE IOWA BOARD OF MEDICAL EXAMINERS'** "DocFinder" web site on the World Wide Web is up and running. Availability of the web site to consumers was announced in late May. The web site contains names, addresses, business telephone numbers, area of specialty, educational background and licensing status for Iowa physicians. The site refers the user to the BME if a disciplinary action has ever been taken against a physician. For more information, the user must call the BME offices for any information which is available as a public record. The new data base makes Iowa one of seven states to offer physician profiles through a web site created and maintained by a consortium of state medical board directors. The web site address is http://www.docboard.org. Click on "DocFinder".

•**JOHN DEERE HEALTH CARE** has notified IMS that it is forming two new provider networks. In April, John Deere entered into an agreement with HCF, Inc., an Iowa Health System physician organization, to create a new primary care provider network in 11 central Iowa counties and seven eastern Iowa counties. Both networks consist of primary care physicians, specialists and hospitals connected with HCF. The notification to IMS was made according to the Principles of Agreement for Managed Care negotiated by the IMS, major payers and other organizations representing health care.

•**TERESA MOCK, MD** has been elected chair of the Iowa Board of Medical Examiners. She replaces James Collins, MD, who remains on the Board but chose not to run for reelection as chair. Dr. Mock is a family physician from Mason City and has served on the BME since 1994. James Caterine, MD, a general surgeon from Des Moines, was elected vice chair replacing Laura Stensrud of Lake Mills. Dr. Mock and Dr. Caterine are both IMS members.

•**A TUTORIAL FOR COMPLETING THE MEDICAL CERTIFICATION** cause-of-death section on death certificates can be found on the Internet. The tutorial has been prepared by Dr. Randy Hanzlick, death certification project coordinator for the National Association of Medical Examiners and is based on principles developed by the CDC. You may reach the tutorial at: http://www.TheNAME.org. When you find the NAME home page, select "Help with Cause-of-Death Statements".

•**CIGARETTE VENDING MACHINES** may not be removed as quickly as FDA wants. According to FDA regulations, machines and self-service cigarette displays that are accessible to children must be removed by the end of August; however, that will be delayed until the US Court of Appeals decides a case that challenges FDA's authority to regulate tobacco use. During the 1997 Iowa Legislature, IMS supported legislation to allow local governments to develop their own youth access rules. The bill was stalled by the tobacco industry.

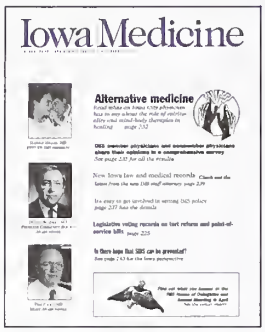
•**1996 E & M UTILIZATION DATA FOR MEDICARE** is now available. IMS members can access that data on the IMS website or by sending a self-addressed business envelope to the IMS, Attn: Practice Management Department, stating the specialties for which they would like copies.

•**AN HISTORIC AGREEMENT HAS BEEN REACHED** between tobacco companies and state attorneys general after months of negotiations. Lawsuits filed by 40 states, including Iowa, resulted in the agreement Attorney General Tom Miller called "a comprehensive plan that could have a huge impact on reducing the terrible harm caused by tobacco."

For more information about any *DEADLINE* news item, call Chris McMahon at IMS headquarters, 515/223-1401 or 800/747-3070.

Iowa Medicine

JOURNAL OF THE IOWA MEDICAL SOCIETY JULY–AUGUST 1997 / VOLUME 87 / 6



About the Cover

1997 IMS award winners pictured on this month's cover are Dr. Dennis Boatman of Cedar Rapids, winner of the Physician Community Service Award; and Dr. Tom Foley of Marshalltown, winner of the Merit Award. Also pictured is Dr. Harold Miller of Davenport, 1997-98 IMS president.

Don't miss the IMS survey results of Iowa practicing physicians on page 235.

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FEATURE ARTICLES

"The only constant is change" 217

In his speech to the House of Delegates, the new IMS president urges physicians to pursue common goals innovatively. *HAROLD MILLER, MD, IMS PRESIDENT*

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Timesaving tips for research on the Internet; hot sites for physicians, medical students

Birth of a new eastern Iowa clinic 221

Physicians' Clinic of Iowa may be in its infancy, but its goal is becoming the preeminent provider of clinical care in eastern Iowa.

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IMS strategic planning task force members, *p. 223* . . . Iowa Legislature passes IMS' top two priorities, *p. 225* . . . Why are patient satisfaction surveys necessary and how do physicians participate? *p. 229* . . . The latest in Medicare reimbursements, *p. 230*

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The role of spirituality and mind-body therapies in healing is explored in this article. *EVAN KLIGMAN, MD*

IMS survey reflects physicians' concerns, future needs 235

Iowa physicians responded to a myriad of questions on topics such as health care delivery, public health issues, electronic billing and what the IMS can do for physicians.

Is prevention of sudden infant death syndrome now a reality? 243

There is hope of eradicating SIDS through education. *HERMAN HEIN, MD*

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Recording medical history is worthwhile for county medical societies. *LOUIS GRECO, MD*

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"The only constant is change"

My fellow physicians, you have honored me by electing me to this challenging office. I will seek to do honor to that office and to serve you in accordance with the finest traditions of the Iowa Medical Society.

My predecessor, Bill McMillan, certainly honored the office and the IMS, compiling a record of innovation and service that is at once enviable and challenging.

I do not come into this office intending to reinvent everything. Thanks to the fine work that has been accomplished before me, there is no need to do that. But neither do I come into this office as a mere caretaker. It is my intention to direct the efforts of this organization to the following goals.

Your organization will undergo an extensive strategic planning effort. This task is in evolution and with the help of our capable staff and Board of Trustees will further materialize. Most importantly, you, the members of the IMS, will provide the guidance to culminate this effort.

We will use this strategic planning to reinvigorate our medical society. We will define our core values and build our future firmly grounded on those core values.

To deliver clear benefits of membership to all of our members more effectively and more efficiently, we will develop and refine methods of converting information into knowledge.

We are in the middle of an information revolution; a revolution that is changing society as well as our organization. Quoting the well-known futurist Frank Feather, if automobiles had evolved at the same rate as information management (the computer) over the past 20 years, we would have autos that get 240,000 miles per gallon and cost a nickel.

We are confronted with times of extremely rapid change, an environment where the only constant is change. We must seek and find our common needs in this evolving landscape.

To meet the challenge of this anomalous future, I invite disagreement and debate, but always in the spirit of cooperation and in pursuit of our common goals. We must explore the diverse voices arising from our varied and multifarious backgrounds in order to find solutions; to sift through information in order to refine it.

It is not sufficient merely to preserve and maintain the gains of the past, but constantly to develop and innovate.

Let us put aside "me" and "you" in order to devote our energy to "us." Then let us build on our collective experience, which teaches that it is not sufficient merely to preserve and maintain the gains of the past, but constantly to develop and innovate.

I cannot promise to solve all of the problems that confront us, but I do pledge to devote 100% of my mind, heart and will to meeting all of the great challenges ahead. I look forward to working with you and for you. IM



HAROLD MILLER, MD
IMS PRESIDENT

EDITOR'S NOTE:
Dr. Harold Miller gave this speech to the Iowa Medical Society House of Delegates on Sunday, April 20 following his inauguration as 1997-98 IMS president. Dr. Miller is a family practitioner from Davenport.

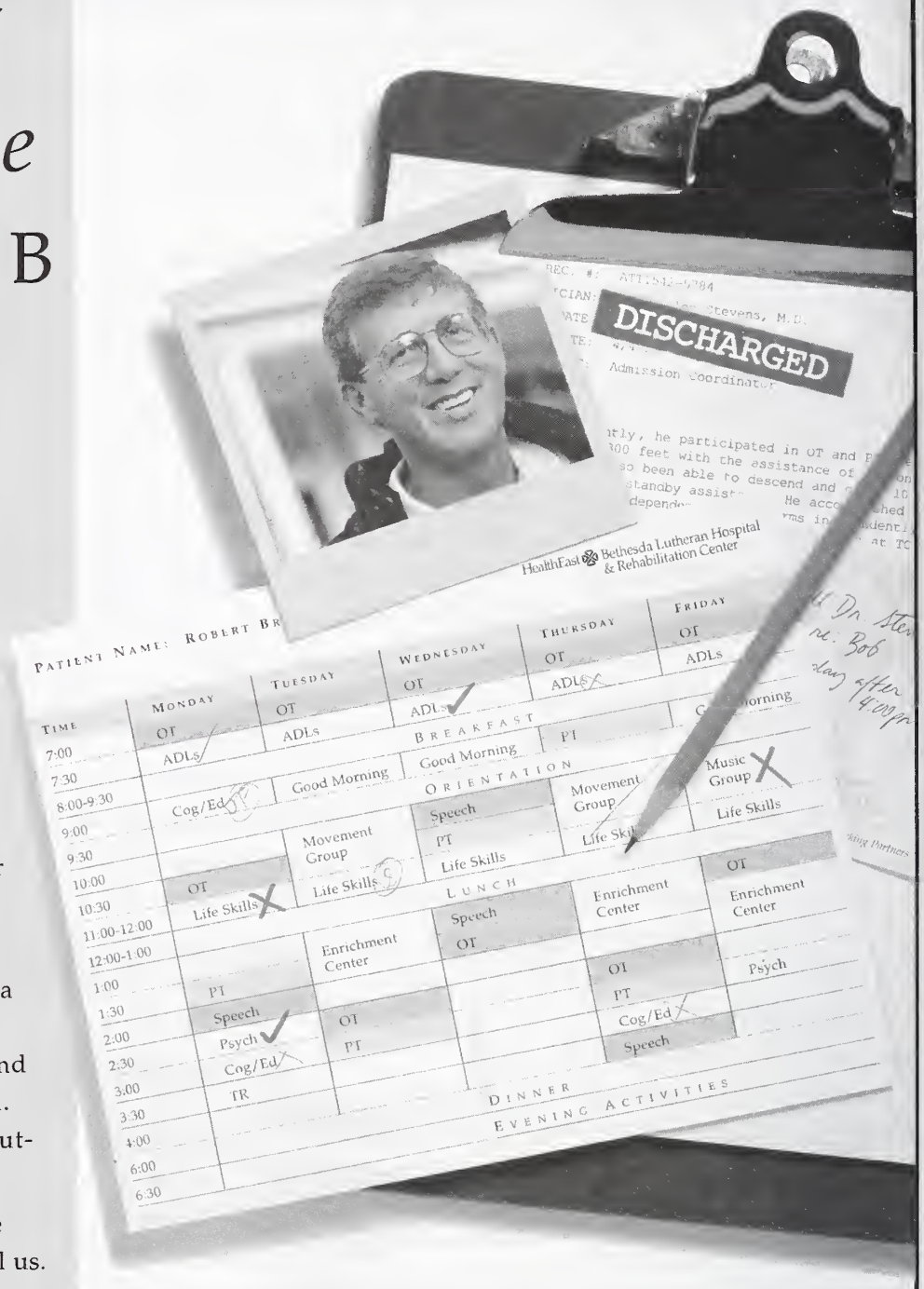
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New on the Net

Research on the Internet

It's important to give some thought to your search strategy. Are you just beginning to amass knowledge on a fairly broad subject? Or do you have a specific objective in mind?

If you're interested in broad, general information, the first place to go is to a web directory like Yahoo. *www.yahoo.com*

Yahoo works as a hierarchical subject index, allowing you to drill down from the general to the speeific.

Web directories usually come equipped with their own keyword search engines that allow you to search through their indices for the information you need.

For medical information, Medsite Navigator (*www.medsitenavigaor.com),* AVICENNA (*www.avicenna.com*) and the Hardin Meta Directory of Internet Health Sources (*www.arcade.uiowa.edu/hardin-www/md.html*) are great web directories.

Using a search engine such as AltaVista (*www.altavista.digital.com*) and Excite (*www.excite.com*) for research is trickier.

Take a look at "The Spider's Apprentice" (*www.monash.com/spidap5.html*), an online guide for getting the most from searches.

One of the guide's top tips—always take a look at each search engine's help documents. These pages will help you narrow your searches, so you get the information you need.

Also, be as specific as possible when typing in keywords. Don't type *car* when you could type *Toyota*.

Tie keywords together with conjunctions such as AND or OR. You ean exclude keywords by using NOT. For example, you may search for documents eontaining "alzheimer's AND treatment NOT symptoms" to find new treatments for Alzheimer's disease, not case studies of patients with the disease.

To further narrow your search, take advantage of some search engines' abilities to search for phrases and to constrain document searches to certain dates.



Linking IMS physicians to the information they need

Hot sites

Residency search: The AMA's "Fellowship and Residency Electronic Interactive Database Access system," otherwise known as FREIDA, contains information on over 7,500 graduate medical education programs and 200 combined specialty programs. Users receive profiles of programs that match entered selection criteria. FREIDA is free and even offers users mailing labels for up to 30 programs. *www.ama-assn.org/med-sci/medsci.html*

Caffeine fix: Coffee lovers should be sure to check out "Coffee A GoGo," an entertaining site dedicated to Americans' favorite morning drink. The site features recipes for coffee drinks, an interesting history of coffee, a chat room called the Buzz and the URL Percolator which sends visitors to different coffee sites. *www.illuminatus.com/fun/agogo/coffee_a_gogo.html*

Cyberounds: Dress is casual for "Cyberounds," interactive online rounds moderated by distinguished academics, exclusively for physicians and medical students. Registration is required, but the service is free. Among the 15 conferences being offered in June were women's health, cardiovascular medicine, geriatrics and nutrition. The site also has a chat room and a moderator's quiz for which the doctor with the first right answer receives a prize. *www.cyberounds.com* IM

IMS staff members are on the watch for sites that might interest Iowa physicians. Staff members visit all Hot sites *to make sure they have useful information and reasonable download times. Suggestions for* Hot sites *can be sent to Melanie Finke by e-mail at communic@netins.net or by telephone at 800/747-3070.*

Mercy-Harvard Executive Program in Health Policy and Management

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- Information Systems for Managed Care and Integrated Delivery Networks
- Performance Measurement in Health Care
- Integrated Delivery Systems
- Resource Allocation
- Public Policy Strategies in Health Care

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1997		1998	
September	19	January	16
October	17	February	20
November	14	March	20

Fridays (8:30 a.m.-4:00 p.m.)

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Birth of a new eastern Iowa clinic

(Tenth in a series)

Physicians' Clinic of Iowa, PC began functioning as a fully-integrated organization of 45 physicians on April 1 of this year. The most immediate challenge of this new entity has been to pull five independent groups into an integrated clinic with a groupthink.

According to James, Flynn, MD, cochair of the clinic's marketing committee, Physicians' Clinic of Iowa was formed because physicians became aware of threats that were arising against their patients and their practices. Dr. Flynn remarks that "hospitals, insurance companies and HMOs began taking the lead in health care which meant that patient advocacy was needed and could be accomplished effectively only through a large group."

Advantages for physicians and patients

The clinic's physicians can see the benefits of delivering health care through a large group and Wilson Strong, Jr., MD, president of Physicians' Clinic of Iowa, believes the community is also beginning to see that value as well. "At all times, we will be the patients' advocate. And now we will have the structure and information systems necessary to make the internal adjustments and demonstrate to purchasers of health care that we provide value through quality care."

An increased ability to provide the highest quality, most effective medical care is the biggest advantage for PCI's physicians. Dr. Flynn offers numerous other advantages for their integrated organization: ability to do CQI/QA/UR, access to a sophisticated computer system, ability to negotiate contracts and belonging to a group governed and owned by physicians.

All 45 physicians are shareholders in PCI. The seven-member physician board of directors makes all decisions for PCI except major monetary decisions which are made by the shareholders.

Surgical and medical care services

Medical services provided through PCI include general surgery, neurosurgery, occupational medicine, rheumatology, neurology, podiatry, orthopedic surgery, hand surgery, ENT and urology.

The clinic also plays a part in community education, injury and illness prevention and community health policy development.

"Preeminent provider in eastern Iowa"

Dr. Strong believes his main charge as president of PCI is to follow the vision and values developed by the founding steering committee. According to its vision statement, the clinic "exists to become the preeminent provider of clinical care in eastern Iowa . . . We commit to emerge as the responsible leader in adapting to the changing dynamics of our emerging health care system through continuous quality improvement techniques and a patient/community health outcomes focus."

Advice for Iowa colleagues

Dr. Flynn and Dr. Strong have wise words of advice for other Iowa physicians who are wondering how to get organized to face the future. First of all, develop a common purpose and vision and make sure everyone is moving in the same direction. And secondly, hire a good consultant. IM

"Develop a common purpose and vision and make sure everyone is moving in the same direction."

KEY CONTACTS:

Physicians' Clinic of Iowa, PC
Cedar Rapids
319/398-1500

James Flynn, MD
Secretary

Wilson Strong, Jr., MD
President

Nevin Meredith
Executive director

If you know of other innovative practice arrangements we should write about in Iowa Medicine *— especially those controlled by physicians and positioned to compete in the managed care market — call Barb Cannon or Chris McMahon at the IMS, 515/223-1401 or 800/747-3070.*

Betting on a bright future



IMGMA Fall Meeting
October 22-24, 1997
Harvey's Hotel and Casino
Council Bluffs, Iowa

IMS Update

Strategic planning process in full swing

Last January, nearly 1,100 Iowa physicians answered a survey conducted by the Iowa Medical Society. The survey was the first component of a comprehensive strategic planning process being undertaken by the IMS this year. As promised, the results of the survey appear on page 235.

In addition to the survey, focus groups, leadership retreats and telephone interviews are being conducted throughout the summer months.

A task force on strategic planning has been appointed by Harold Miller, MD, IMS president. The members are: Sterling Laaveg, MD; John Brinkman, MD; Siroos Shirazi, MD; William McMillan, MD; Jose Angel, MD; Hunter Fuerste, MD; Beth Bruening, MD; Bill Kuyper, MD; Tom Evans, MD; Steve Wolfe, MD; Greg Garvin, DO; Michael Disbro, MD; Charles Helms, MD and Kathryn Opheim, MD.

News at a glance

The Iowa Board of Medical Examiners is now online with its entire data base of almost 10,000 licensed Iowa physicians. The public can access the data base, search for an Iowa-licensed physician by name and read a brief profile that includes the physician's business address, telephone number, area of specialty, educational background and licensing status. If a physician has faced board discipline or is currently facing charges, the public will be alerted by an on-screen notation that indicates some form of disciplinary information is on file at the board's Des Moines office. The new data base makes Iowa one of only seven states to offer physician profiles through a web site created and maintained by a consortium of state medical board directors known as Administrators in Medicine.

Dr. Miller recently spoke for the entire task force when he commented, "We have a deep commitment to reinventing and rebuilding this organization." Task force members would be happy to hear comments or questions from member physicians regarding the IMS strategic planning.

Watch future issues of *Iowa Medicine* for updates on the strategic planning process. IM

News from Iowa Medical Group Management Association (IMGMA)

IMGMA and legislative advocacy

The IMGMA is committed to being actively involved in government relations. Working together with the Medical Group Management Association, four representatives participated in the May MGMA Legislative Advocacy Workshop in Washington, DC. We made visits to our congressional delegation to discuss:

- Provider sponsored organizations—Creation of community networks of providers in the Medicare program would provide a needed alternation to HMOs. Current proposals would preempt state regulations for four years with federal solvency and consumer protection standards.
- Physician payment issues—HCFA is attempting to implement a resource-based practice expense relative value units system to reimburse practice expenses. Concerns are being widely expressed that it is based on inadequate calculations using flawed data resulting in large cuts for some procedures. We hope to achieve a delay so adequate data can be obtained.
- Fraud and abuse—The Administration has proposed "The Medicare and Medicaid Fraud and Abuse and Waste Prevention Amendments of 1997." This would repeal the fraud and abuse provisions Congress passed last year which were favored by MGMA as they provide an increased degree of fairness to physicians.

Our fall annual meeting will be held October 22-24 at Harvey's Hotel and Casino in Council Bluffs. The focus will be on government relations and current issues.

(This article was written by Dana Petrowsky, IMGMA executive director.)

IMS Update
continued

Specialty Society Update

New members of the Iowa Psychiatric Society executive council are Alan Korbett, DO, secretary-treasurer; James Trahan, MD, member at large and C. Scott Jennisch, MD, member in training.

American Medical Directors Association, Iowa Chapter annual fall membership meeting will be held in Iowa City September 12-13.

The Iowa Association of Pathologists Board of Directors met with Blue Cross Blue Shield and Medicare medical directors in April.

The Iowa Radiological Society's new officers are: Marine Schularick, MD, president; Richard Kundel, MD, president-elect and Timothy Grissom, MD, secretary-treasurer.

The Iowa Association of County Medical Examiners board of directors met in May. They discussed the new law on county recovery of costs related to homicide victims with Thomas Bennett, MD, state medical examiner.

The Iowa Vascular Surgery Society's new officers are: Timothy Kresowik, MD, president; John Klosak, MD, vice president and John Stern, MD, secretary-treasurer.

The Iowa Oncology Society met in June to discuss current issues with private carrier denials, Medicare and plans for the October 24 education meeting in Iowa City.

Focus on IMS Alliance

The Healing Path

The Healing Path: A Guide to Surviving Domestic Violence made its debut in Polk County at a press conference on March 31 in honor of Doctors' Day and Medical Alliance Month.

The original concept for the handbook was presented at an AMA/ABA Regional Conference on Domestic Violence in Chicago last year. Barbara Bell, IMSA chair of Community Violence, adapted the handbook for Iowa with the help of over 23 professional consultants to assure accuracy of information. It is designed to provide legal information, options and resources to victims of domestic abuse.

Polk County has distributed over 5,000 copies of *The Healing Path* to clinics, physicians, ERs, churches, schools, police departments, sheriff's offices, county attorneys, senior homes and shelters. A second printing of 30,000 copies will make this valuable resource available primarily to victims in the Polk County area this summer.

Anyone who would like a copy of *The Healing Path* should contact Barbara Bell at 304 52nd Street, Des Moines, Iowa 50312.

The Alliance is excited about the possibility of working with the Iowa Medical Society on a venture which will adapt *The Healing Path* to every county in Iowa.

(This article was written by Cindy Ehrecke, IMSA president.)

Physicians Honored with Doctors' Day Donation to AMA-ERF

Hospital administrators and IMSA members donated $2,865 to AMA-ERF in honor of physicians on Doctors' Day. AMA-ERF (American Medical Association Education and Research Foundation) provides grants to medical schools for student financial aid and to fund student research. Twenty-four individuals, one county alliance and three hospitals made donations. Following are the names of those physicians honored by individuals and contributing hospitals:

Andrew Andresen, MD
James Bell, MD
Fred Carpenter, DO
Francis Conway, MD
Charles Crouch, MD
Dean Ehrecke, MD
Harold Eklund, MD
Eugene Foss, MD
Robert Godwin, MD
Philip Habak, MD
Paul Holzworth, MD
James Kimball, MD
Sterling Laaveg, MD
Gary LeValley, MD
Nick Messamer, MD
Harold Miller, MD
Ronald Miller, MD
Joseph Pollpeter, MD
Clifford Rask, MD
David Rater, MD
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Dennis Rolek, DO
Martin Sands, MD
R. Bruce Trimble, MD
Peter Silberstein, MD
Peter Szeibel, MD

A donation was given in memory of Robert Foss, MD

Donations were also given in honor of the Genesis Medical Center, Davenport; Marshalltown Medical & Surgical Center and MMSC Auxiliary; North Iowa Mercy Health Center, Mason City and Dubuque County Medical Society.

Legislative Affairs

Legislature passes IMS' top two priorities

The 1997 session of the Iowa legislature was very successful with passage of managed care point-of-service bill and a reduction in the statute of limitations for minors, the Iowa Medical Society's top two priorities. Governor Branstad has signed both the point-of-service bill and the civil justice reform bill containing the statute of limitations reduction proposed by the IMS.

Managed Care Choice

The IMS has won a significant victory with passage of the point-of-service bill, HF 133, providing for patient choice of physicians under managed care. The IMS has worked for this bill as part of a broad-based coalition which includes business associations, other health care provider associations and insurers who have agreed to this bill as a reasonable compromise.

HF 133 requires employers with over 50 employees who provide health benefits to offer to employees at least one of three plans providing coverage for a patient's choice of physicians. The choices are a traditional indemnity plan, a managed care plan with an unrestricted provider network or a point-of-serviee plan which provides coverage for services provided by physicians outside the network. Patients may be required by the plan to pay a higher premium, deductible or copayment based on the actual additional cost of administering this feature. Small employers, who typically have more difficulty providing and administering health benefits, must be offered these options by purveyors of health benefits but are not required to offer them to employees.

Legislators view this bill as a reasonable compromise between the concerns of employers over health benefit costs and the concerns of patients and providers over ensuring that the full range of care is available to the employee/patient.

News at a glance

The AMA has endorsed HR 1122, the bill on intact dilation and extraction (D & E or partial birth abortion). Having been significantly changed to meet AMA criteria, HR 1122 now (1) makes it clear that D & E is not covered by the bill; (2) permits the procedure to save the life of the mother without any obligation to show that "no other procedure would suffice," and (3) does not restrict use of the procedure for physicians intending a delivery at the outset (i.e., it can be done as necessary in their best medical judgment).

Governor Branstad has signed legislation into law affecting parking permits issued to persons with disabilities. Physicians and chiropractors are no longer required to sign the parking permit and patients diagnosed with life-long disabilities can be issued non-expiring parking permits, rather than permits that must be renewed every four years. Patients with the orange-colored permits must obtain a new permit by December.

All legislators voted for this bill (except three absent).

Civil Justice Reform

Passage of HF 693, the tort reform bill, was another significant victory for the IMS. In its final form, the bill reduces the statute of limitations for minors to 8-plus-2 years so the normal two-year statute of limitations starts running when a child reaches age eight. For example, a lawsuit alleging a birth or early childhood injury would have to be filed before the child's tenth birthday. The bill also requires the Iowa Department of Public Health and the University of Iowa to compile data on access to obstetrical services in Iowa.

The IMS has been part of a Civil Justice Reform Coalition advocating for a comprehensive tort reform bill. The original bill included 12 key points, including a $250,000 limit on noneconomic damages and a reduction in the statute of limitations for minors in medical liability cases.

Because of strong opposition from the plaintiffs' bar, both the cap and the statute of limitations sections were removed by the House Judiciary Committee as well as several other items. The language that remained in the bill was generally weak and needed extensive improvement to be meaningful. While this

Be sure to thank your legislators who voted with the IMS on the tort reform bill and amendments. Call or write them at home or arrange to meet with them. Call Cheryl Peers at the IMS for home addresses and phone numbers.

Legislative Affairs
continued

The IMS has worked for the point-of-service bill as part of a broad-based coalition which includes business associations, other health care provider associations and insurers.

was very disappointing, House leadership and the Judiciary Committee chair worked with the IMS to amend HF 693 to include our statute of limitations language, as well as to improve the other portions of the bill. Unfortunately, the coalition found that there was simply not enough support in the current legislature to add the cap on noneconomic damages.

The House vote on statute of limitations amendment was as follows:

Aye **(IMS position):** Arnold, Barry, Blodgett, Boddicker, Boggess, Bradley, Brauns, Brunkhorst, Bukta, Carroll, Churchill, Corbett, Cormack, Dix, Dolecheck, Drake, Eddie, Garman, Gipp, Greig, Greiner, Gries, Grundberg, Hahn, Hansen, Heaton, Holmes, Houser, Huseman, Jacobs, Jenkins, Klemme, Kremer, Lamberti, Larson, Lord, Martin, Mascher, May, Mertz, Metcalf, Meyer, Millage, Nelson, O'Brien, Rants, Rayhons, Siegrist, Sukup, Teig, Thomson, Tyrrell, Van Fossen, Van Maanen, Vande Hoef, Veenstra, Weidman, Welter.

Nay: Bell, Bernau, Brand, Burnett, Cataldo, Chapman, Chiodo, Cohoon, Connors, Dinkla, Doderer, Dotzler, Drees, Falck, Fallon, Foege, Ford, Frevert, Holveck, Huser, Jochum, Kinzer, Koenigs, Kreiman, Larkin, Moreland, Mundie, Murphy, Myers, Osterhaus, Reynolds-Knight, Richardson, Scherrman, Schrader, Shoultz, Taylor, Thomas, Warnstadt, Weigel, Whitead, Wise, Witt.

Collateral Source Amendment

An amendment originating with the plaintiffs' bar was offered in the House to repeal one of the most significant tort reforms ever passed in Iowa, Iowa's collateral source law. This law prevents double recovery on claims from both the regular insurance carrier and the malpractice insurance carrier. The law was passed in the mid-1970s and is considered by experts to be nearly as significant as a cap on noneconomic damages in holding the line on premiums. The amendment to repeal this law, sponsored by Moreland, was soundly defeated.

The House vote on collateral source amendment was as follows:

Aye: Bell, Bernau, Brand, Bukta, Burnett, Cataldo, Chapman, Chiodo, Cohoon, Doderer, Dotzler, Drees, Falck, Fallon, Foege, Ford, Frevert, Holveck, Huser, Jochum, Kinzer, Koenigs, Kreiman, Larkin, Mascher, Moreland, Mundie, Murphy, Myers, O'Brien, Osterhaus, Reynolds-Knight, Richardson, Scherrman, Schrader, Shoultz, Taylor, Thomas, Warnstadt, Weigel, Whitead, Wise, Witt.

Nay (IMS position): Arnold, Barry, Blodgett, Boddicker, Boggess, Bradley, Brauns, Brunkhorst, Carroll, Churchill, Corbett, Cormack, Dinkla, Dix, Dolecheck, Drake, Eddie, Garman, Gipp, Greig, Greiner, Gries, Grundberg, Hahn, Hansen, Heaton, Holmes, Houser, Huseman, Jacobs, Jenkins, Klemme, Kremer, Lamberti, Larson, Lord, Martin, May, Mertz, Metcalf, Meyer, Millage, Nelson, Rants, Rayhons, Siegrist, Sukup, Teig, Thomson, Tyrrell, Van Fossen, Van Maanen, Vande Hoef, Veenstra, Weidman. Absent: Connors, Welter.

The Senate vote on the bill was as follows:

Aye **(IMS position):** Angelo, Bartz, Behn, Black, D., Boettger, Borlaug, Douglas, Drake, Flynn, Freeman, Hedge, Iverson, Jensen, King, Kramer, Lundby, Maddox, McCoy, McKean, McKibben, McLaren, Redfern, Redwine, Rehberg, Rensink, Rife, Rittmer, Schuerer, Tinsman, Zieman.

Nay: Connolly, Dearden, Deluhery, Fink, Fraise, Gettings, Gronstal, Halvorson, Hammond, Hansen, Harper, Horn, Judge, Kibbie, Neuhauser, Palmer, Szymoniak.

Worker's Compensation

SF 296 provides that in the event of a dispute between a worker's compensation insurance carrier and an employee's regular health plan over who should pay the health care bills, the health insurance carrier is required to pay health care providers who have already provided services. The two carriers can then resolve their dispute over who pays, without physicians or hospitals being caught in the middle. The IMS worked with the Association of Iowa Hospitals and Health Systems in support of this bill. Since the state is preempted by federal Employee Retirement Income Security Act (ERISA) from regulating self-insured health plans, this bill will not provide relief in cases where benefits are provided through a self-insured plan. The new law will apply to services rendered after July 1, 1997.

Certificate of Need

SF 236, increasing the dollar thresholds when a certificate of need is required, has been passed by the legislature. Current law requires a certificate of need for new services costing $300,000 or more or replacement services costing $400,000 or more. SF 236 would increase thresholds to $1.5 million in most cases. Current law also contains a list of three

services for which CON approval is always required for hospitals, regardless of cost: (1) cardiae eatheterization serviee, (2) open heart surgical service, and (3) organ transplantation service. SF 236 adds "radiation therapy service applying ionizing radiation for the treatment of malignant disease using megavoltage external beam equipment" to that list and would require physician offices and clinics to receive CON approval for providing the four listed services. Current law exempts physician groups from that list. The IMS opposed requiring physicians' offices to receive CON approval for any additional services. However, the IMS worked with Senator John Redwine to modify the original language in the bill to be more acceptable. The IMS has opposed the CON process since it began in the 1970s. The IMS supports raising the dollar thresholds.

Utilization Review

The IMS bill to require Iowa licensure of physicians who perform utilization review relating to medical care provided in Iowa did not get out of committee. The bill faced significant opposition from the insurance and managed care industries.

Abortion Reporting

The legislature passed SF 128 requiring physicians to report induced and spontaneous abortions to the Iowa Department of Public Health. There are strict confidentiality protections in the bill. The IMS is neutral on the reporting requirement, but has worked to minimize the administrative burden of reporting.

Parental Notification and Video

The legislature has also passed HF 121 whieh modifies a law passed in 1996 requiring a minor's parents to be notified prior to the minor receiving an abortion. As of July 1, in most cases physicians will no longer be required to offer viewing of a video to pregnant minors. HF 121 will only require that the video be offered by physicians from whom a minor is seeking an abortion. Last year's law also allowed notification of a grandparent or aunt or uncle in place of a parent, but the legislature dropped the provision allowing notification of an aunt or uncle. A judicial bypass procedure is also provided. The bill addresses issues brought up in a court case which has delayed implementation of the parental notifieation requirement.

IMSA Domestic Violence Bill

In a surprise action the IMS Alliance proposal to require a warning on marriage certificates that spouse abuse is illegal was adopted in a conference committee report on HF 612 dealing with child support recovery.

Board of Medical Examiners

The Iowa Board of Medical Examiners (IBME) will receive a budget increase of $150,000 to cover increasing costs, particularly the additional costs of litigation. An attempt was made by legislators to use a portion of the IBME budget to fund another program. IMS lobbyists explained to legislators that the IBME is funded from physician license fees which are required by law to be used for licensure and disciplinary functions. The money was restored.

Medicaid

In spite of a recommendation from the Council on Human Services for a Medicaid reimbursement increase for physicians and other providers, no additional funds were appropriated for this purpose.

University of Iowa College of Medicine

The legislature has also approved $27 million over a three-year period for construction of new medical education and biomedical research facilities at the University of Iowa. $800,600 was appropriated for the primary health care initiative in the College of Medicine, with $330,000 of that amount allocated to the department of family practice.

CHMIS

The legislature reduced a requested appropriation of $300,000 for CHMIS to $200,000 and gave $60,000 of the remainder to the Department of Human Services for a telemedicine pilot project and Medicaid payments for telemedicine. IM

Medical Economics

News at a glance

According to Hospitals and Health Networks *(May 5 edition), a Hawkins and Associates survey of 300 residents found 86% preferred a salary or salary plus bonus, up from 55% two years ago. Only 11% want an income guarantee, down from 41% in 1995. There was increased interest in working for multispecialty groups, with a proportionate decrease in interest in single specialty practice.*

In the same issue of Hospitals and Health Networks, *a report by WDHI Capital Markets and KPMG Peat Marwick found health care industry earnings grew by 14.2% in the fourth quarter of 1996 compared to previous periods, but HMO earnings took a beating. Physician practice management company earnings increased 50.9%, home health care companies increased 49.1% and for-profit hospitals increased 17.2%. HMOs declined 6.5%.*

Jeanine Freeman joins IMS staff

In April the Iowa Medical Society brought Jeanine Freeman, JD on board to head up the public policy and advocacy department. Jeanine brings a lot of experience to the Society with an extensive background in health law. Prior to joining the IMS staff, she was an attorney for Iowa Hospitals and Health Systems and practiced for a law firm specializing in health and government regulatory issues.



Jeanine Freeman

Check out Jeanine's new column dealing with legal issues which is making its debut in this issue of *Iowa Medicine* (page 239).

AMA opposes HR 1362

The AMA went on record last week in opposition of HR 1362, the Veterans' Medicare Reimbursement Demonstration Act of 1997, because it would create inappropriate competition for Medicare patients between veterans facilities and the private sector.

In its letter to the House Veterans' Committee, the AMA also expressed concerns about the financial solvency of Medicare Part A and B and made the point that any new obligations would only hasten the insolvency situation.

Although the AMA is committed to ensuring adequate funding for VA hospitals and clinics to care for their patients, it is urging the VA to eliminate unnecessary or duplicative services.

Idaho signs first-in-the-nation bill

Idaho Governor Phil Batt signed into law what is believed to be the first bill requiring managed care plans to provide a point-of-service option. The measure was part of a comprehensive patient protection bill that prohibits gag clauses; prohibits managed care plans from providing financial incentives to reduce, limit or delay medically necessary care; requires disclosure of consumer information; and appeals processes and requires plans to designate obstetricians/gynecologists as primary care providers.

Health and anti-tobacco advocacy caucus

The AMA recently hosted a caucus of health and anti-tobacco advocacy groups to provide an open forum for them to voice their opinions, strategies and concerns about the ongoing tobacco industry settlement talks to those representing public health at the table.

In the wake of the meeting, the AMA has been receiving high praise from the advocacy community for taking a leadership role in convening the meeting which was cosponsored by the American Cancer Society, American Heart Association, American Lung Association, American Public Health Association and the Center for Tobacco-Free Kids.

The Iowa Medical Society is supporting several major anti-tobacco efforts, including the lawsuit by Governor Branstad and Attorney General Miller against tobacco companies. IM

DATA & TECHNOLOGY

IMS develops patient satisfaction survey

The Iowa Medical Society has joined forces with the Association of Iowa Hospitals & Health Systems (IH&HS) to create patient satisfaction surveys that will be used in physician clinics and hospitals. Based on responses received to date, the project will soon have many clinics using the standard survey.

The project was first conceived in 1996. The IMS identified data as a strategic initiative and has been looking for projects that will assist physicians in analyzing their practices. Staff recommended that a standard patient survey should be developed which would allow physicians to compare results with peers from across the state and nation.

At the same time the IMS was formulating a plan on implementing such a system, IH&HS staff members were doing the same. Both organizations agreed that becoming partners on this project would be more efficient, improve the quality of the survey instruments, encourage more widespread use throughout hospitals and physician clinics and lower the cost.

Prime vendor selected

Seven firms specializing in patient surveys responded to a request for information. Five of these were asked to give detailed presentations in January to representatives from clinics and hospitals. Healthcare Research Systems (HRS) was the unanimous selection by IH&HS and IMS.

HRS is a research and consulting firm based in Columbus, Ohio. Born out of the College of Medicine at Ohio State University, HRS is now an independent firm specializing in health care research. In addition to surveying patients for clinics and hospitals, half of HRS clients are health plans which contract to survey patients about overall satisfaction with the health plan to meet HEDIS requirements.

Physicians and clinic administrators met at IMS headquarters to develop the standard survey. The group started with surveys HRS uses with other clinics across the US, then proceeded to add and delete questions and change the wording of others. Clinics that choose to use this survey have some flexibility to add questions unique to their needs.

The IMS has developed a standard patient satisfaction survey for use in physician clinics. Standardization will allow excellent comparability between physicians.

Why survey patients?

Any business interested in continuous quality improvement must survey customers to ensure that a high degree of satisfaction is being obtained. In today's competitive health care marketplace, patients are losing their ability to choose physicians. Those patients that have a high degree of loyalty to a physician, partly grown out of positive encounters with a clinic, will choose a health plan in which their physician is a member.

Patient surveys can be used for internal quality improvement efforts, meeting HEDIS and health plan requirements, marketing, etc.

The IMS patient satisfaction survey is a standard instrument that will be used by all participating clinics. This standardization will result in an ability to compare your results of patient satisfaction to other Iowa physicians. These scores can be used in marketing your services to the public, health plans and employers and should be an integral part of your internal quality improvement initiatives.

How do I participate and what do I get?

The surveys are ready for use in your clinic now. The cost to a group practice should be less than $4,500 per year depending upon the level of detail and options the clinic desires. The cost to a solo practitioner is considerably less. The clinic will receive quarterly reports of patient responses. IM

For more information, call Ed Whitver, vice president of administration, 515/223-1401 or 800/747-3070.

Practice Management

News at a glance

Beginning July 1, 1997, physicians who submit claims for diagnostic clinical laboratory tests conducted in their offices may not be eligible for reimbursement from Medicare. HCFA has instructed Medicare insurance carriers to deny claims if the office laboratory has an expired CLIA certificate. Medicare carriers have also been advised to reject those claims for diagnostic tests not approved under the current CLIA certificate. Starting October 1, 1997, HCFA will also require all claims for laboratory services performed in a physician's office to include the CLIA number on the claim as a condition for payment. Claims for diagnostic laboratory services without CLIA numbers will be returned as incomplete claims.

CLIA update

The Iowa Department of Inspections and Appeals (DIA) will be notifying 250 physician office laboratories that are billing Medicare for testing that is outside their current certificate type or billing with an expired or terminated CLIA certificate. The DIA needs to determine whether the laboratories are conducting tests outside their certificates or whether coding errors are occurring. Following are the most common coding errors:

- Whole blood glucose using a device approved by the FDA for home use should be coded as 82962 and not 82947 or 82948.
- Strep A using a waived kit should be billed as 86588QW and not simply 86588.
- Dipstick UA without microscopy should be billed using 81002, not 81000. The code 81000 should only be used if both a microscopic examination and dipstick urinalysis are performed.

MBS graduates give program high marks

Two office managers recently completed the Medical Business Specialist Certification Program: Jo Worth and Debi Kendall.

Jo Worth (Dr. Martin Key, Atlantic) completed the eight core classes of the MBS program in one year. "The MBS program is a very educational, well presented program that provides usable information for the medical office. With all of the changes taking place in the medical field we need a source of dependable education," remarked Ms. Worth.

Debi Kendall (Fox Eye Institute, Cedar Rapids) joined the MBS program June 1996 and completed the program February 1997. "After 25 years in the health care field the MBS offered an opportunity to expand my knowledge in a variety of areas," commented Ms. Kendall. IM



Jo Worth



Debi Kendall

Practice Management Workshops for You

The ABCs of Compliance Programs
July 14, 17, 21, 24, 28, 31
Omaha, Waterloo, Burlington, Fort Dodge, Cedar Rapids, Davenport
Practical guidance on the creation/implementation of an effective compliance program to reduce your risks if audited or reviewed. Instructors: Barb Cannon and Barb Pierce, IMS staff.

Medical Terminology
September 9, Cedar Rapids

Office Safety & Compliance Issues
September 10, Mason City

Office Communication Skills
September 16, West Des Moines; September 17, Davenport

ICD•9•CM Coding
September 24, West Des Moines

For more information or to register for any IMS practice management workshop, call Sherry Johnson at IMS Services, 515/223-2816 or 800/728-5398.

Midwest Medical Insurance Company Focus on Risk Management

Consent to treat minors

A 17-year-old girl went to her physician's office to pick up an authorization to participate in high school sports. She was also complaining of a rash so the nurse advised her to have it looked at by a physician. An appointment was made for later in the day. Following the physician's examination she received an injection of Benadryl. Later, her mother became very angry when she found out her daughter had received treatment without her authorization.

The authorization of a parent or legal guardian is usually necessary before rendering medical care to a minor. Malpractice claims and disciplinary actions by licensing boards have been brought against physicians and clinics alleging failure to obtain parental consent. Often, these cases arise when the physician assumes that a minor has discussed the proposed procedure or treatment with their parent or guardian and then proceeds with the treatment without confirming that consent has actually been obtained.

In Iowa there are a few exceptions to the parental or guardian consent requirement:

- Emergency situations do not require parental consent when the risk to the minor's life or health is of such a nature that treatment should be given without delay or denial of treatment. However, every effort should be made to obtain consent of the parent or guardian as soon as possible.
- Emancipated minors who are living apart from their parents or guardians and managing their own financial affairs may consent to their own treatment. Any minor who has been married may give consent. Documentation of the minor's claim of emancipation should be present in the medical record.
- Minors may voluntarily apply for services to diagnose or to treat HIV, sexually transmitted diseases, mental illness, alcohol and other substance abuse. The minor is entitled to confidentiality regarding the treatment; parents and legal guardians should be informed about the treatment only when, in the judgment of the physician, failure to inform the parent or guardian would seriously jeopardize the health of the minor. However, minors must be told that positive HIV test results must be reported to their parents or legal guardian.

For more information contact Lori Atkinson, MMIC risk management supervisor, Midwest Medical Insurance Company, West Des Moines Office, PO Box 65790, West Des Moines, Iowa 50265; 800/798-9870 or 515/223-1482.



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"After the sale, it's the SERVICE that counts"

The role of spirituality and mind-body therapies

Alternative medicine

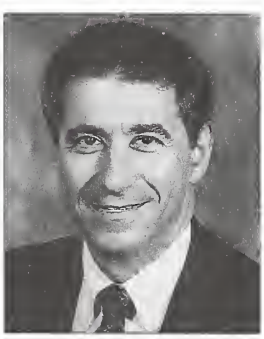


Much attention is given to alternative and complementary therapies by the media and our patients. Well over 40% of the US population uses some form of unconventional (not allopathic or osteopathic) medical care. This feature focuses on the role of spirituality and other mind-body therapies in healing.

The broader concept of "alternative" or "integrative medicine," may be useful to describe the evolving efforts of practitioners to combine evidence-based ideas and practices of conventional and unconventional medicine.

In 1991, the National Institutes of Health established the Office of Complementary and Alternative Medicine (OCAM) to support research and development of knowledge on over 150 recognized alternative therapies. Senator Tom Harkin (D-IA) was responsible for the legislation that led to the establishment of OCAM.

These therapies are divided into six general areas: diet/nutrition/lifestyle changes; mind-body therapies; traditional and ethnomedicine; structural and energetic therapies; pharmacological and biological treatments; and electromagnetic applications.



Evan Kligman, MD
Dr. Kligman is professor and head of the Department of Family Medicine at the University of Iowa College of Medicine, Iowa City.

A survey of members of the AAFP revealed 99% of the physicians believed a patient's spiritual beliefs contribute to healing.

Spirituality defined

Recently, there has been an increasing interest in the connection between healing and spirituality. Spirituality may involve the practice of a particular religion, but is more often used to describe the relaxation and comfort appreciated by people derived from contemplating spiritual values outside of a religious context.

Both in the popular media and medical journals, scientific evidence is accumulating on the power of prayer, both directed (to a person for a specific desired outcome) and undirected (for general support without intent for specific outcome), on the healing process. Research studies suggest a positive role of prayer in recovery from both acute and chronic diseases, as well as in decreasing pain and discomfort even when survival is not prolonged. In over 200 studies, people observant in their religious faith or who maintain spiritual activity have lower blood pressure, lower risk of heart disease, and reduced levels of adrenaline and cortisol which can be associated with impaired resistance to disease and high stress levels.

One of the most important predictors of survival after bypass surgery was the extent to which patients drew strength and comfort from religion, according to a 1995

study by Dartmouth medical school. A recent Time/CNN poll showed the majority of people think physicians should pray with patients who request it. Medical schools, including the University of Iowa, are incorporating curriculum in spirituality and healing and offering pastoral counseling to patients. A survey last year of members of the American Academy of Family Physicians revealed 99% of the physicians believed a patient's spiritual beliefs contribute to healing. Studies of centenarians consistently reveal the maintenance of spiritual values as a key attribute in longevity.



The mind and body connection

Mind-body therapies focus on the interrelationship between mind and body with the goal of promoting overall health by combining mental and physical approaches. Examples are body psychotherapy, yoga, biofeedback, guided imagery, hypnotherapy, meditation, and the relaxation response. Research over the past 15-20 years has more clearly elucidated the interaction between psyche, nervous system, and immune function (psychoneuroimmunology).

Body psychotherapy includes a range of techniques founded on the belief that psychological and physical healing go hand in hand. Such practitioners assert that we feel our emotions not only in our brain, but also in our body. Thus, techniques (including dance therapy and therapeutic massage combined with traditional psychotherapy) are designed to reintegrate the mind and body. Common among these treatments is a focus on breaking down or disintegrating rigid emotional patterns.

Yoga has been developed over thousands of years and is rooted in the Ayurvedic Medicine tradition. This technique involves a series of body positions and movements to calm the mind, relax the body and ease the spirit. Meditation and breathing exercises are incorporated into cycles of stretches and poses. As with all mind-body techniques, yoga can be a valuable adjunct or complementary therapy when combined with conventional treatment programs for acute and especially chronic problems with an emotional stress component, such as asthma and bronchitis, digestive disorders, back problems, arthritis, insomnia, depression and anxiety, menstrual disorders, varicose veins and hypertension.

Biofeedback incorporates the use of a computerized machine to measure physiological functions such as heart rate, skin temperature, muscle tension, and brain activity and display data. By monitoring data representing these functions, patients can better control their body through stages of rest and activity. Biofeedback has been especially useful, often as adjunctive therapy to pharmacologic or counseling interventions, in treating stress-related conditions, asthma, migraine headaches, hypertension, anxiety and chronic pain.

Therapeutic, or guided imagery teaches patients to imagine scenarios to influence certain physiological conditions. This approach usually begins with a 20-minute relaxation ex-

The practice of conventional physicians should incorporate an assessment of their patients' use of what are now alternative therapies.

continued

ercise to help the patient focus attention and center the mind. The focus is on a predetermined image designed to help the patient control a particular symptom or disease process. Often, hypnotherapy or an audiotape can facilitate imagery. Research has shown imagery has impact on immune function, decreasing blood pressure, reducing gastrointestinal disorders and the spontaneous healing of skin rashes. A classical use of this therapy is with a cancer patient who will imagine chemotherapy as bullets shot at a malignant tumor.

Medical schools, including the University of Iowa, are incorporating curriculum in spirituality and healing and offering pastoral counseling to patients.

Hypnotherapy provides the patient with a relaxed and focused state of awareness to help change physiological and psychological reactions to pain, illness or anxiety. Self-hypnosis techniques can be learned by patients and are often prescribed to control hypertension, stop smoking, decrease anxiety, control allergies and asthma and heal skin rashes.

Meditation includes a spectrum of Western and Eastern practices where the patient sits or rests comfortably, with eyes often closed, and performs "mindfulness" wandering or focused attention on a mantra, providing relaxation for the body with concentration. Mental processes are brought under voluntary control to enhance physical and psychological well-being. Scientific evidence since the 1960s has shown that the various meditative techniques are effective in quieting the sympathetic nervous system, slowing down both heart rate and respiratory rate, lowering blood pressure and metabolic rate. Meditation is often prescribed for the treatment of stress-related conditions, anxiety, hypertension, phobias, headaches, chronic pain and sleep disorders. These techniques have also shown to be successful in treating drug and alcohol dependencies.

Physiologic benefits

The purpose of most of the mind-body techniques is to induce a "relaxation response" to lower oxygen consumption, reduce heart rate and blood pressure, reduce muscle tension, relieve stress and provide the patient with a state of psychological and physiologic rest. Harvard's Dr. Herbert Benson, who coined the phrase "relaxation response," believes that "anywhere from 60% to 90% of visits to doctors are in the mind-body, stress-related realm."

Many health professionals today believe we are evolving a more comprehensive paradigm of health care that will incorporate various treatments with evidence-based efficacy that are cost-effective. The significant increase in research over the past three decades on the efficacy of alternative therapies, comparative studies of costs and outcomes using alternative vs. conventional approaches and the explosion of interest among patients and health delivery systems, are driving us toward the eventual practice of integrative medicine.

Following important safeguards (evidence-based research, assuring safety and appropriate training and licensing of providers), unconventional therapies of proven efficacy may become blended into mainstream medicine. A growing number of managed health care organizations have started to incorporate many of these therapies into mainstream coverage for their beneficiaries.

A complementary approach

The practice of conventional physicians should incorporate an assessment of their patients' use of what are now considered alternative therapies. When and if the physician becomes comfortable with and knowledgeable of certain alternative therapies, his or her practice can then include patient counseling, guidance and information on which techniques may be effective as adjunct or complementary approaches to medical problems that may also be treated with more conventional methods. IM

IMS survey reflects physicians' concerns, future needs



Forty-two percent of Iowa physicians responding to a recent survey said that rules of managed care companies which intrude into the physician/patient relationship are their primary concern.

The survey was conducted earlier this year by the Iowa Medical Society as the kick-off to a comprehensive strategic planning process which will take most of this year. Over 5,000 surveys were mailed to IMS member and nonmember physicians; 20% responded.

Other "number one" concerns cited by Iowa physicians answering the survey included burdensome government regulations, lack of preparation for dealing with managed care, the tort system, dwindling compensation for services, competition from larger provider groups and expanded scope of practice of allied practitioners.

Working with the BME to ensure license and discipline procedures are fair to physicians was cited by 74% respondents as very important.

Changing your practice arrangement?

In one portion of the survey, physicians were asked about the nature of their practice. Thirty-five percent of members and nonmembers practice in a single specialty group; 22% are in a multispecialty group.

Thirty-seven percent practice in groups of 2–5 physicians, 19% are in groups of 6–10 physicians and 10% are in groups of 11–20 physicians. Only 9% said they practice in groups of over 100 physicians.

Nearly one-fourth of those answering the survey said they are considering a change in their practice arrangement. The change being considered by most of these physicians is adding physicians to their group. Sixteen percent of respondents who said they are considering a change cited "form an alliance with another practice" as the change they are considering. Fifteen percent are looking toward a merger with another practice. Six percent of members and 6% of nonmembers said they plan to sell their practices and become employees of the purchaser.

Forty-nine percent of physicians answering the survey said they were in primary care (family practice, internal medicine, pediatrics, obstetrics/gynecology or general practice).

Public health issues

Iowa physicians were also asked to rank the top three public health issues which should be a focus for the Iowa Medical Society. Their

Iowa physicians ranked the top three public health issues which should be a focus for the IMS as tobacco use, teen pregnancy and drug and alcohol use.

continued

choices? Tobacco, teen pregnancy and drug and alcohol use. There was no difference of opinion between members and nonmembers on these issues.

Diet/exercise habits, family violence and end-of-life issues were also mentioned by a significant number of physicians as being issues of concern. Less than 10% of respondents chose the environment, alternative medicine or HIV/AIDS as one of their top three issues of concern.

Nearly one-fourth of those answering the survey said they are considering a change in their practice arrangement.

The world of cyberspace

The survey posed a number of questions designed to measure the involvement of Iowa physicians in technology. These results were surprising — only 7% of Iowa physicians said they have no access to a computer. The rest have access either at home, at work or both. Forty-two percent of the physicians who currently have no access plan to buy a computer this year.

Nearly three-fourths of Iowa physicians said they bill patients electronically. Sixty-six percent of those responding said they have access to the Internet; 81% of those said they use e-mail.

What can the IMS do for physicians?

Much of what the IMS does for physicians is considered to be important by those responding to the survey. Specifically, the most important services IMS provides are:

•Working with the Board of Medical Examiners to ensure that license and discipline procedures are fair to physicians (73% of respondents said this is "very important").

•Providing information to physicians and staff about laws and regulations (71% said this is very important).

•Working with national coalitions to improve Medicare reimbursement for Iowa physicians (70% said this is very important).

•Working with insurers and other third party payers on behalf of physicians (69% said this is very important).

•Lobbying in the Iowa Legislature (68% said this is very important).

•Advising physician offices on CPT and E & M coding (53% said this is very important).

The survey also included a list of services which the IMS could consider providing for physicians and asked respondents to rank their top three priorities. No clear consensus on new services emerged from survey responses. Proposed services which attracted the most interest include:

•Maintaining a network of proven consultants to work with physicians on all aspects of managed care.

•Providing mediation services or a list of proven mediators to resolve conflicts with hospitals, managed care organizations and others.

•Reviewing managed care contracts.

•Purchasing inpatient data bases to help members compare practice patterns to their peers.

•Offer continuing medical education via the Internet.

What happens now?

The results of the survey will be considered by a 15-member strategic planning task foree recently appointed by Dr. Harold Miller, IMS president. The task force will also consider information gathered at focus group meetings held around Iowa in June and discussions at several strategic planning retreats.

Recommendations which emerge from the strategic planning process will be considered by the 1998 IMS House of Delegates, the IMS Executive Council and the IMS Board of Trustees. IM

It's easy to get involved in setting IMS policy

Have you ever wondered where the Iowa Medical Society gets its positions on legislative and other advocacy issues? It is easy to get involved in setting IMS policy.

One way of developing policy is through the IMS House of Delegates which meets annually in late April. The House of Delegates considers resolutions that have come from individual physicians, county medical societies, councilor districts or specialty societies. At the House, each resolution is referred to a five-member reference committee. The committee's role is to listen to discussion on the resolutions from IMS members in an open hearing. Any IMS member, whether a delegate to the House or not, may participate in the discussion at the open hearing; thoughtful debate is encouraged. The committee members meet after the open hearing, consider facts and opinions brought out in debate and develop recommendations based on the greater good of IMS members and their patients. Committee recommendations are discussed and voted on by the full House. Only delegates may vote on the resolutions.

Delegates are chosen by county medical societies and specialty societies. Most interested physicians will find it easy to become a delegate.

Members may also influence policy and its implementation by serving on an IMS committee or task force. Members are appointed by the IMS president. In addition to implementing policies, IMS committees can recommend new or changed policies to either the House of Delegates or the Executive Council. Special task forces are sometimes appointed to study and recommend policy on a specific issue.

The Executive Council is empowered to take action on issues that are brought to it through the IMS committee process. It typically meets three times a year and is able to respond to issues between annual meetings of the House of Delegates. The Executive Council consists of the Judicial Council, representing geographic regions of the state, the Board of Trustees, AMA delegates and alternates and the speaker and vice speaker of the House.

AMA policy also guides the IMS unless the IMS has taken a different position from the AMA. For example, the IMS follows the AMA's extensive policy on tobacco issues rather than restating similar positions.

Policy may be implemented through legislation or by negotiating with state agencies or other organizations.

The IMS Board of Trustees, which is elected by the House, is responsible for prioritizing and implementing policies. The policies are added to the IMS policy compendium and guide IMS actions until the policy is changed or rescinded. Policies may be implemented through legislation or by other means such as negotiating with state agencies or other organizations. IM



BECKY ROORDA

Ms. Roorda is director of public affairs for the Iowa Medical Society.

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Medical records and the Iowa General Assembly

On the Legal Front

This year the Iowa Medical Society successfully wrought a solid legislative victory in passage of HF 693, the tort reform bill. That bill contains two provisions of interest to medical records personnel.

Key in HF 693 is a long-awaited-for amendment to Iowa's statute of limitations for minors. This provision has a direct bearing on medical retention policies.

Current law allows a medical malpractice claim to be filed up to the minor's 19th birthday. HF 693 replaces this statute of limitations for medical malpractice actions with an 8-plus-2 rule: an action on behalf of a minor who was under the age of eight at the time of the alleged act of medical negligence must be filed no later than the minor's tenth birthday, after which medical malpractice actions on behalf of minors are governed by the same time limits as for adults. If the ordinary statute of limitations for medical malpractice actions would grant a longer period of time to the minor, the longer period applies.

Critical to medical records retention is the two-year phase-in of the 8-plus-2 rule. The new statute of limitations applies to all causes of action accruing on or after July 1, 1997 as well as causes of action accruing before July 1, 1997 but filed after July 1, 1999. The old rule remains in effect for all other cases. Records of care and treatment of minors must be retained accordingly.

Critical to medical records retention is the two-year phase-in of the 8-plus-2 rule.

HF 693 also sets forth in statutory form steps to be taken by the defense in obtaining the plaintiff's medical records and for consulting with the plaintiff's physician. Immunity is provided for physicians acting in good faith compliance with HF 693. Physician assistants, advanced registered nurse practitioners and mental health professionals are also covered.

Where the plaintiff's medical condition is at issue, the defense can access the plaintiff's medical records by making a written request upon plaintiff's legal counsel for a legally sufficient patient waiver and release. The sought-after records must relate to the plaintiff's medical condition in question. The plaintiff must execute the waiver and release within 60 days of the receipt of the request. Releases, then, are made based on the patient's signed waiver.

Physicians may charge a reasonable fee for a release of medical records based on actual cost of production and/or for a consult provided in response to a written request.

The waiver also may require the plaintiff's physician to consult with the defense prior to providing testimony. The defense must provide written notice, in the same manner as a notice of deposition, to plaintiff's attorney at least 10 days prior to any meeting with plaintiff's physician. Plaintiff's counsel has the right to be present at the meeting. The meeting can be by telephone conference. IM



Jeanine Freeman

The information in this column is not intended to be legal advice. If you have specific questions or concerns, contact your attorney.

Ms. Freeman is vice president of public policy and advocacy at the Iowa Medical Society.

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PERSONAL FINANCIAL STRATEGIES



JERRY FOSTER

I once heard an analogy about the value of adding international stocks to a portfolio. Imagine adding a scoop of ice cream to a slice of chocolate cake to reduce the dessert's calories. Unfortunately, this is pure fantasy. However, in the world of investing, adding a higher-risk investment like foreign stocks to a portfolio can reduce the portfolio's risk while at the same time increasing the return.

The real driving force behind a portfolio's return is the asset allocation. This works because different assets move up and down in value independently of one another. While the US stock market is going down, foreign stock markets may be going up. The net effect—if you have both types of holdings in your portfolio—is the swings tend to moderate each other. Because both types of assets increase in value over time, your portfolio continues to increase in value, only without as much volatility.

How investments move in relation to one another is called correlation. The more two investments react similarly to market fluctuations, the higher the correlation. A correlation of 1 means identical movement between assets; a correlation of -1 means an exact opposite movement between assets; and a correlation of 0 signifies no relationship in the movement between assets.

Adding a higher-risk investment like foreign stocks to a portfolio can reduce the portfolio's risk while increasing the return.

The correlation between the US stock market and foreign markets is quite low, averaging less than .5 over the 1971-1994 time period. This means the US stock market does not move in concert with the foreign markets.

If the US markets are falling, it's very possible the foreign markets may be going up. In a highly volatile market like we're in, this can be a way to minimize the effect of a major US bear market. Consider the following statistics:

- From 1974 to 1994, the developed world stock market capitalization grew from $892 billion to $12.64 trillion.
- In 1974, the US stock market accounted for 60% of the world market size.
- By the end of 1994, it accounted for approximately 35%.
- From 1971 to 1994, the MSCI EAFE index, the leading international index, produced an annual return of 14.6%.
- Over the same period, the US stock market produced an average annual return of 11%.
- The standard deviation (risk) for the EAFE and US stock market for the same time period was 18.2% and 15.5% respectively.

With these facts in mind, it makes a lot of sense to have international investments in your portfolio. Just as diversification works when investing in the US market, being broadly diversified among numerous regions and countries of the world will help minimize the volatility of your international investments. IM

Jerry Foster is the founder and president of Foster Capital Management, a fee-based financial advisory firm endorsed by the Iowa Medical Society. Mr. Foster can be reached at 1-800/798-1012.



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The Journal
of the Iowa Medical Society

Is prevention of sudden infant death syndrome now a reality?

● *Herman Hein, MD*

Sudden Infant Death Syndrome (SIDS) is a major source of infant mortality and has been the leading cause of post neonatal death for some time. In spite of decades of research, little if anything has been advanced which clearly separates the susceptible infant from others. Accordingly, prevention has not been possible. Because of three recent findings, this may have changed.

First, numerous accounts, largely from foreign countries, brought encouraging news of dramatic reductions in SIDS deaths.[1-3] These reports were associated with infants having been put to sleep in a supine position. No explanation for this salutary effect of back sleeping was apparent until Kemp et al published the second major finding which illustrated how a rebreathing mechanism, consistent with a prone sleeping position, could cause infant death.[4-7] These investigators used several models, one involving live animals, to demonstrate babies could rebreathe their own exhalations. The mechanisms involved trapping exhalations in porous bedding materials (pillows or blankets) or creation of a small breathing pocket such as in the corner of a crib protected with plastic bumper pads. Either mechanism could allow an infant literally to "rebreathe" his own exhalations, lowering blood oxygen levels and increasing blood carbon dioxide levels.

Receptor-binding defect

The reasons why some babies do not recognize that their oxygen and carbon dioxide levels are abnormal became more clear with the third finding provided by Kinney and Filiano et al when they reported on the discovery of a receptor-binding defect in the arcuate nucleus of the medulla.[8] The binding defect is believed to contribute to a failure of response to cardiopulmonary challenges during sleep and hence, ultimate asphyxiation in such nonresponders.

"Back to Sleep" program

How have these new findings been utilized? In 1992, the American Academy of Pediatrics through a "Back to Sleep" program, urged parents and other infant caretakers to position babies on their backs when putting them down to sleep.[9] If this was not feasible, a side position was suggested. In Iowa, the Academy's back sleeping campaign has been continued and we have incorporated the findings of Kemp et al with other information about risk factors for SIDS to form a statewide program aimed at SIDS prevention. The program consists of:

1. Education regarding potential risk factors
 a. Back sleeping (side sleeping is avoided because the position is unstable);
 b. When the infant is put down to sleep, parents are urged to check for rebreathing potential, e.g., soft bedding materials or a small "face pocket" as in the corner of a crib which has been covered with plastic bumper pads;
 c. Avoidance of exposure to tobacco smoke—prenatally and postnatally;[10,11]
 d. Avoidance of overheating.[12]
2. Thorough death scene evaluation.
3. Complete postmortem exams for infants who die suddenly and unexpectedly.

Although SIDS deaths are on a downward trend in Iowa and nationally, I wanted to know if current Iowa sudden infant deaths continue to be associated with prone positioning.[13,14] Also, I was interested to know if Iowa medical examiners were sufficiently aware of the importance of infant sleeping position to adequately describe that position at the death

The IMS Education Fund has designated this article as the Henry Albert Presentation Award for July–August 1997.

Herman Hein, MD
Dr. Hein is professor of pediatrics, University of Iowa Hospitals and Clinics, Iowa City and director of the Iowa Perinatal Program.

Is prevention of sudden infant death syndrome now a reality?

continued

scene. The Iowa Department of Public Health was asked to provide death reports of infants born January 1, 1995 or later, which were coded as SIDS. Herein is a report on the first 20 deaths that occurred during that period.

1995 survey results

In assessing the results of the survey of sudden and unexplained infant deaths in Iowa in 1995, I found only five of 20 cases had an adequate description of the death scene. In 11 instances, there was sufficient information to appreciate the infant's position when he was found to be unresponsive. In nine of these cases, the infant was found lying face down. Only one baby was found on his back and one was found with his face wedged in the side of a recliner chair where he was being held by his sleeping father. In nine cases, the medical examiner's report did not afford sufficient information to ascertain the infant's position. The age range of the patients reported was from five days to six months and the vast majority were between one month and five months of age.

Physician/public education needed

The dearth of specific information about infant position at the time of death suggests medical examiners have not accepted the importance of infant sleeping position as a potential factor in SIDS. In the 11 instances where sufficient information was available to appreciate the infant's sleeping position at the time of discovery, there were nine infants found lying face down. It would appear some parents/caretakers may not be seriously heeding the warnings about prone sleeping.

Perhaps the importance of the message about preventing the potential for rebreathing will not be achieved until a general public awareness is realized. This is because, in many instances, the caretaker at the time of the infant death is not the parent or even the primary babysitter, but rather a person providing care as a substitute and frequently a substitute obtained on short notice. Unfortunately, the substitute is not always knowledgeable about appropriate sleeping positions for infants and tends to rely on the "old tried and true" method of prone sleeping.

Similarly, the medical examiner may not be attuned to pediatric practices and may not have been targeted by the SIDS prevention program. Accordingly, the significance of prone sleeping may not be apparent to some medical examiners.

It may be years before the factor or factors are elucidated that clearly identify the infant at risk for SIDS. Furthermore, when the breakthrough comes, it likely will be some time before the information can be used on a practical level. Thus, we believe it is important to continue to make progress in reducing the incidence of SIDS by bringing the current information about risk factors to light. For reasons described above, this information must be targeted at the general public.

Iowa efforts at reducing SIDS

Efforts in Iowa have been stepped up with radio and television advertisements aimed at the public. Also, an attempt has been made to incorporate this message in health education taught in public schools. Hopefully some infant deaths can be prevented by having all babysitters and child caretakers aware of the importance of avoidance of prone sleeping.

Protocols allowing for more complete death scene reporting and better postmortem evaluations have been incorporated statewide. Medical examiners have been targeted for special educational sessions that explain the importance of these new protocols. These efforts should augur for more precise information about why and how Iowa infants die suddenly and unexpectedly.

We have been helpless to prevent the tragedy of SIDS. We have decried the lack of knowledge about cause and hence have accepted our helplessness to identify risk. Now, even though our understanding about SIDS is not complete, our ability to impact the incidence of the disease may no longer be tied to ignorance, but only our own resolve. Even though the incidence of SIDS will likely be decreasing when final 1994 and 1995 mortality data become available, the data presented herein suggest that we can do better. With a concerted effort, we can do it now.

References

References are available from either the author or the editors of *Iowa Medicine*. IM

University of Maryland

Medicine in Iowa: take a look back

● *Louis Greco, MD*

What do you do when you're asked to write a history of medicine in your county? This task was assigned to me by the Boone County Sesquicentennial Commission with the requirement that it be completed before the end of 1996. It was impossible for me to produce a comprehensive history in less than nine months, but I decided to do the best I could within the given time frame.

A group effort

I asked for the help of 17 persons to each furnish an article on a specific topic concerning health care. Since my specialty had been general surgery, I decided to write an article on Boone County surgeons and to update the biographical sketches of doctors who had practiced in the county during the last 150 years. The biographical sketches had been published 25 years ago in Dr. Longworth's *History of Medicine in Boone County*.

Each of the writers used their individual methods of researching their subject. I sent questionnaires to the doctors, reviewed obituaries of doctors and contacted doctor's relatives to update the existing biographies and to add new ones. My topic, "Surgeons of Boone County," was prepared by using my personal knowledge of the men, anecdotal material, obituaries, memorials, announcements, museum artifacts and documents, medical society pictures, records of the medical society and records of the hospital staff.

Boone County medical history

Metaphorically speaking, a seed was planted. After nine months of struggle during the gestational period, labor pains followed and the newborn entity arrived. It was named *Boone County Medicine: A Look Back (1846-1996)*. The text still needed aftercare to serve the purpose of its creation—the distribution to interested readers.

We decided to publish and market the book with the help of the Boone County Historical Society which would receive all of the profit. A master copy was assembled and copies of the text were made and bound at a copying facility as orders were received. The soft bound books were priced at $35 and hard bound at $75. One hundred twenty copies have been sold. The book is now available to the public in eight Iowa libraries.

The book contains approximately 350 pages (archival paper) and includes more than 100 pictures and illustrations. It contains information about the first physician in Boone County, the first physician in the city of Boone, a pioneer woman physician, surgeons of Boone County, family practitioners of Boone County, the offices and clinics of the doctors, the pharmacies, the growth of the Boone County Hospital, Woodward State Hospital, the changes in the practice of medicine, and the progress in anesthesia. It also has many pictures of doctors, doctor's offices, pharmacies, and the hospital. There are also photographs of old documents including diplomas, certificates, obituaries and an old fee schedule. Dr. Longworth's entire 80-page book was included.

How many of the county medical societies in Iowa's 99 counties have a written history? This question prodded me to do some inquiring. I asked the state libraries about the magnitude of their book collection pertaining to medical histories of Iowa counties and if they had dedicated a space in their library for such a collection. The library of the State Historical Society of Iowa in Iowa City sent me a 30-page bibliography containing information about the history of medicine in Iowa housed in their library. There were 181 journal arti-

Metaphorically speaking, a seed was planted. After nine months of struggle during the gestational period, labor pains followed and the newborn entity arrived. It was named *Boone County Medicine: A Look Back (1846-1996).*

Louis Greco, MD
Dr. Greco is a general surgeon from Boone.

Medicine in Iowa: take a look back

continued

cles about the history of medicine in Iowa in the general category. Medical histories pertaining to specific counties were shelved with other historical information in a section dedicated to that county. Twenty-three out of 99 counties had no recorded history of medicine listed under their counties. The library is very interested in obtaining medical histories of the counties of Iowa and would be an excellent repository for this material.

Worthwhile project for county societies

Why should each county produce a record of their past activities? Roots are important for individuals. Most of us want to know who we are and where we came from. The same is true to a lesser extent for an organization. A written history gives an organization a sense of pride in its past. It honors those who labored to provide the benefits available to the present. In turn, we in the present deserve that same honor and remembrance in the future. A recorded history tends to provide a common bond and comradeship among members of an organization.

The research, writing, and assembling of the material to produce a history will provide a worthwhile project for the county's medical historian who most likely will be a retired physician. Perhaps a physician who is looking for a meaningful activity to occupy his or her time during retirement would be available for this assignment. It is enjoyable work with little stress.

If the medical history of a community is not recorded, much important historical information will be lost forever. Each year it becomes more difficult to recoup the facts. At this time it is necessary to go back for only 150 years. An initial attempt, even if incomplete, will be a nucleus for future historians to build upon.

There is a place provided for county medical histories in the library of the State Historical Society of Iowa. Copies of written histories of various counties should be sent for storage in that library and other libraries to provide information for future historians. IM

Medical Gems

● *Charles Maplethorpe, MD*

Corn oil for strawberries and cradle cap

Falling occasionally results in abrasions (strawberries). Many times the abrasions contain imbedded dirt or foreign material. The lesion is sensitive and the application of water is very painful. Debridement can be done painlessly using corn oil. The best technique is: apply the corn oil; then allow the patient to cleanse the abrasion (using a stroking motion) with gauze or a soft bristle brush.

Cradle cap results in an unhappy baby and a worried mother. Applying corn oil to the scalp results in immediate relief for both mother and child.

Asthma attact aborted

A person with asthma may be able to abort an asthmatic attack by using a breathing exercise. The goal of the exercise is to decrease the size of the lungs. While in a sitting position, exhale through pursed lips for three seconds while bending forward; then inhale through the nose for not over half a second while straightening up. Repeat the cycle of respirations six times. The result is normal breathing. If not, repeat the exercise. Inhaling through the nose enhances the action of the diaphragm.

How to give painless shots

Everyone giving a subq or IM injection wants to make it as painless as possible. Many ease the needle through the skin and then inject the fluid as rapidly as possible. That technique causes pain.

A better technique is: use the proper length of needle; insert the needle up to the hilt as rapidly as possible; then inject the fluid so slowly that the action is painless.

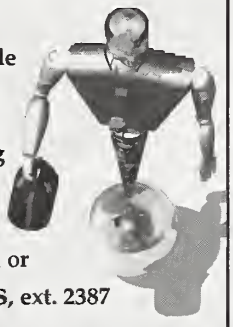
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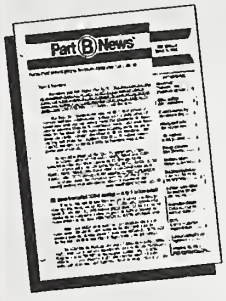
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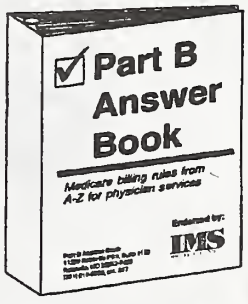
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Take a real vacation

Though many embark on vacations during the winter months, summer is the traditional vacation season. For some a vacation is only a period of exemption from work; for others extensive travel or recreation. The British and other cultures use the term "holiday," defined as a period of relaxation when one is exempt from work. Relaxation is the key word here. So many of us actually feel the need for additional rest after a vacation or holiday to recover from the hours of driving, meeting airline connections and energy spent on athletic endeavors, e.g. tennis, mountain climbing, cycling, etc. The act of competition on such vacations can hardly be called relaxation. For those of my readers who would argue this point, I will not become involved. To return from a period of exemption from work tired, sunburned and tense is to refute the reason for a vacation. Yet, it is the American way to "go for the gusto;" for some it is unAmerican to be just plain lazy with freedom from the tensions of daily livelihood.

The ideal vacation is to be away from the usual environs and to be involved in a completely different lifestyle. My choice for the ideal vacation is an ocean cruise. Once aboard ship, be it for a few days or a couple weeks, the daily tedium is gone. One can become involved in shipboard activities in any way desired; none or some. Just to read a good book or look out to the seas and meditate on the good life is truly relaxing.

Shore excursions are available to see new sights and emerge oneself in various cultures of which we read in travel magazines. Again, each person is given the opportunity to do as desired. Even so, there are some who wish to become greatly involved (can't let go of the old" gotta keep going" routine). Personally, I like to be moderate in the shore excursions. I find it interesting to fortify myself with some knowledge of each port of call and seek what would satisfy my curiosity.

One other thing: it is interesting to meet new friends and continue to keep them as friends for years afterwards. We have had shipboard friends visit in our home and we have visited them in theirs. Our lives have been enriched.

It is the American way to "go for the gusto;" for some it is unAmerican to be just plain lazy with freedom from the tensions of daily livelihood.

One last thing: I have quit taking hundreds of photographs. Once developed they are viewed once or twice and then placed into an album or a box to serve as nothing more than accumulations of the past.

I urge my readers to take a real vacation, a respite from daily life. Return home refreshed and replenished with good memories rather than a sunburn and weary bones. Incidently, my wife and I are embarking on another cruise in June. Wish us bon voyage! IM



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(Continued next page)

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ADVERTISING: Jane Nieland, *Iowa Medicine*, 1001 Grand Avenue, West Des Moines, Iowa 50265. Phone 515/223-1401.

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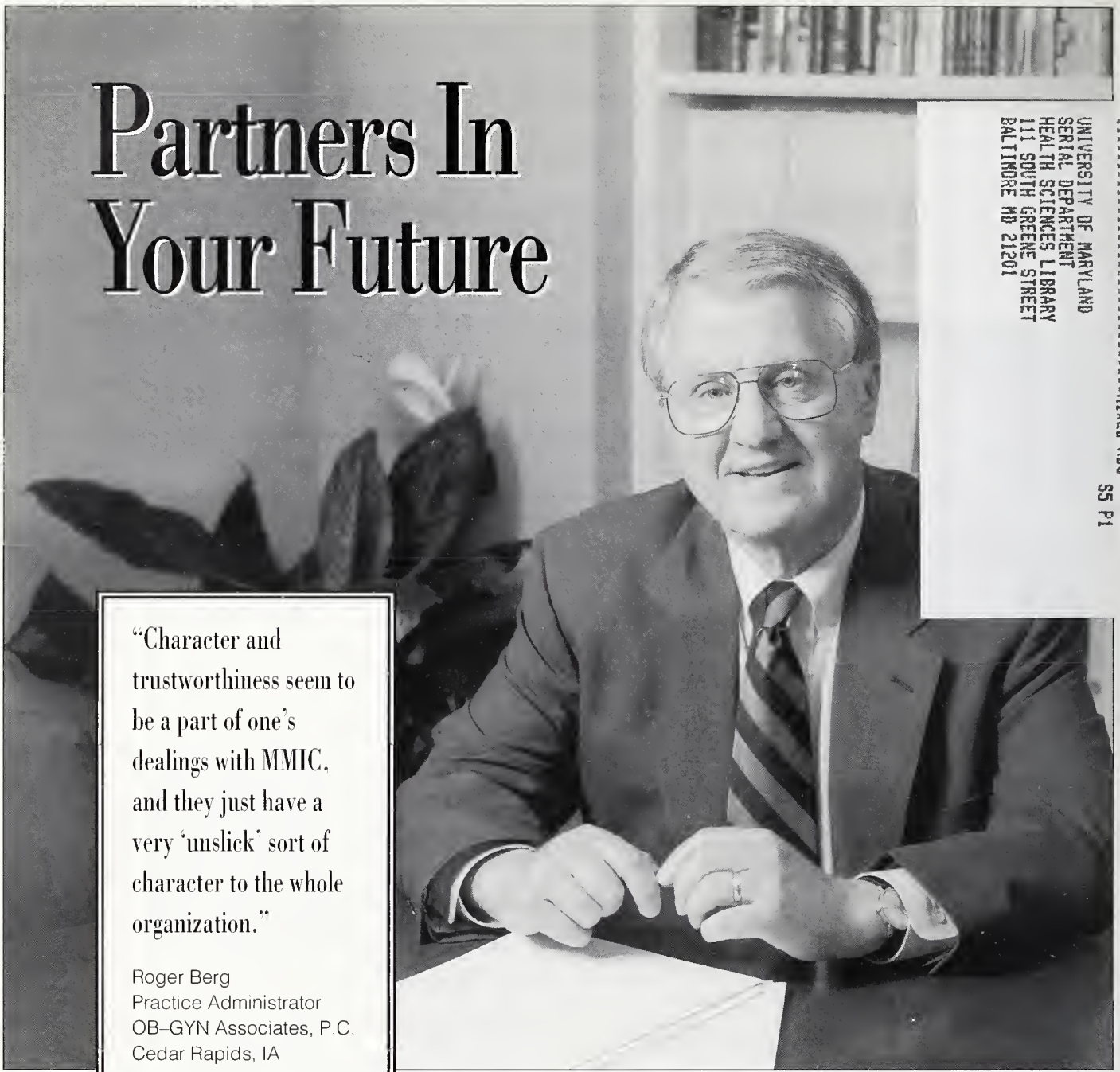
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STACKS

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IMS *DEADLINE* news

September, 1997

Late-breaking news of interest to Iowa physicians

•**IOWA MEDICAID WILL CONTINUE TO PAY** Medicare cost-sharing at the Medicare rate. A change in federal law (see page 270) authorizes states to pay Medicare cost-sharing amounts for persons dually eligible for both Medicare and Medicaid and for Qualified Medicare Beneficiaries (QMBs) at the lower Medicaid rate. Iowa, however, will not exercise its federal option. The Department of Human Services (DHS), the agency responsible for Iowa's Medicaid program, stated that repricing "is not an effective way to control Medicaid costs". Rather, DHS will focus on an "ongoing commitment to expand its use of managed care" to assure cost-effective, quality health care for Medicaid beneficiaries. According to DHS, about 44,000 of Iowa Medicare beneficiaries are dual eligibles; about 5,600 are QMBs.

•**THE IMS COMMITTEE ON LEGISLATION** meets this month to begin discussing IMS priorities for the 1998 Iowa Legislature. The committee will make its final recommendations in November. IMS has been told by legislative leaders that health care issues will not be a top priority during the next session.

•**IMS PRACTICE MANAGEMENT STAFF** are finalizing plans for a series of educational programs on the new single system examination criteria (see page 272 of this issue). The programs will begin late this month over the Iowa Communications Network. There will be nine three-hour evening programs in 20 Iowa cities. The programs are designed especially for physicians. IMS is the only organization doing education on the new criteria; Medicare is referring all requests for programs to IMS. Watch your mail for additional details on how you can register for this important program.

•**THE CENTERS FOR DISEASE CONTROL** is collaborating with the Iowa Department of Public Health Diabetes Control Program and the Iowa Diabetes Oversight Committee to present a live interactive national satellite broadcast on diabetes October 30 from noon until 2 p.m., central time. The event will be broadcast from CDC headquarters in Atlanta with a live audience including diabetes experts from many disciplines. The broadcast will be available at 19 sites in Iowa. The program will highlight diabetes as a national public health issue. For more information on how to participate, call 515/242-6516. At the 1996 IMS House of Delegates, Iowa physicians approved a resolution regarding the importance of regular checkups for patients with diabetes.

•**IMS STRATEGIC PLANNING IS PROGRESSING** on schedule. Three focus groups were held in Cedar Rapids, Des Moines and Storm Lake in June, followed by in-depth telephone interviews with "key stakeholders" outside the IMS. This month, IMS leadership will hold a weekend retreat to begin discussing the Society's future direction. The September retreat will be followed by four retreats involving the 15-member IMS Strategic Planning Task Force. The IMS core values, mission and governance will be analyzed. If you would like your name included on a list of IMS physicians who will receive periodic updates on recommendations emerging from this process, call Chris McMahon at the IMS.

•**IMS STAFF HAVE NEW INDIVIDUAL E-MAIL** addresses which replace the old system of departmental e-mail. The new addresses begin with the staff person's name, for example, *mabrams@iowamedicalsociety.org*. You can e-mail any IMS staff member through the IMS web site.

For more information about any *DEADLINE* news item, call Chris McMahon at IMS headquarters, 515/223-1401 or 800/747-3070.

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Through unity and teamwork our medical profession can pull together to deal with issues such as Medicare reform. *HAROLD MILLER, MD, IMS PRESIDENT*

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Prevention of subsequent coronary events 283

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JENNIFER ROBINSON, MD

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Clarity of purpose

We are dealing with challenging times for medicine. Soon this will be exemplified by massive changes in Medicare.

Only a unified message will clearly express our concerns with elected officials or others. Disunity is too often perceived as disarray. Multiple messages project a muddled weak image.

We can ill afford to leave the impression that our profession lacks clarity of purpose in dealing with Medicare reform. The complex issues that will arise in Iowa need our varied input, but wherever possible we need to present a cohesive perspective for the benefit of our patients.

At the AMA annual meeting in June, a delegate from South Dakota was asked why he voted against a resolution that was supported by his specialty. He responded he was not there to represent one medical specialty, but to represent the physicians of South Dakota and the medical profession. I admire his dedication to duty and the clarity of purpose with which he functions.

We can ill afford to leave the impression that our profession lacks clarity of purpose in dealing with Medicare reform.

I believe the IMS Board of Trustees and the remaining leadership of our Iowa Medical Society serve with the same selflessness. We can all be proud of their efforts to seek solutions and evolve policy motivated by professional interests and not by personal agendas. I wish more of you could see the process in action. In addition, the administrative staff of the IMS remains at the ready to help us sort through these complicated issues.

The challenges presented by changes in Medicare laws and the massive onslaught of managed care plans certain to follow will not be dealt with effectively by seeking solace in one narrow view or perspective.

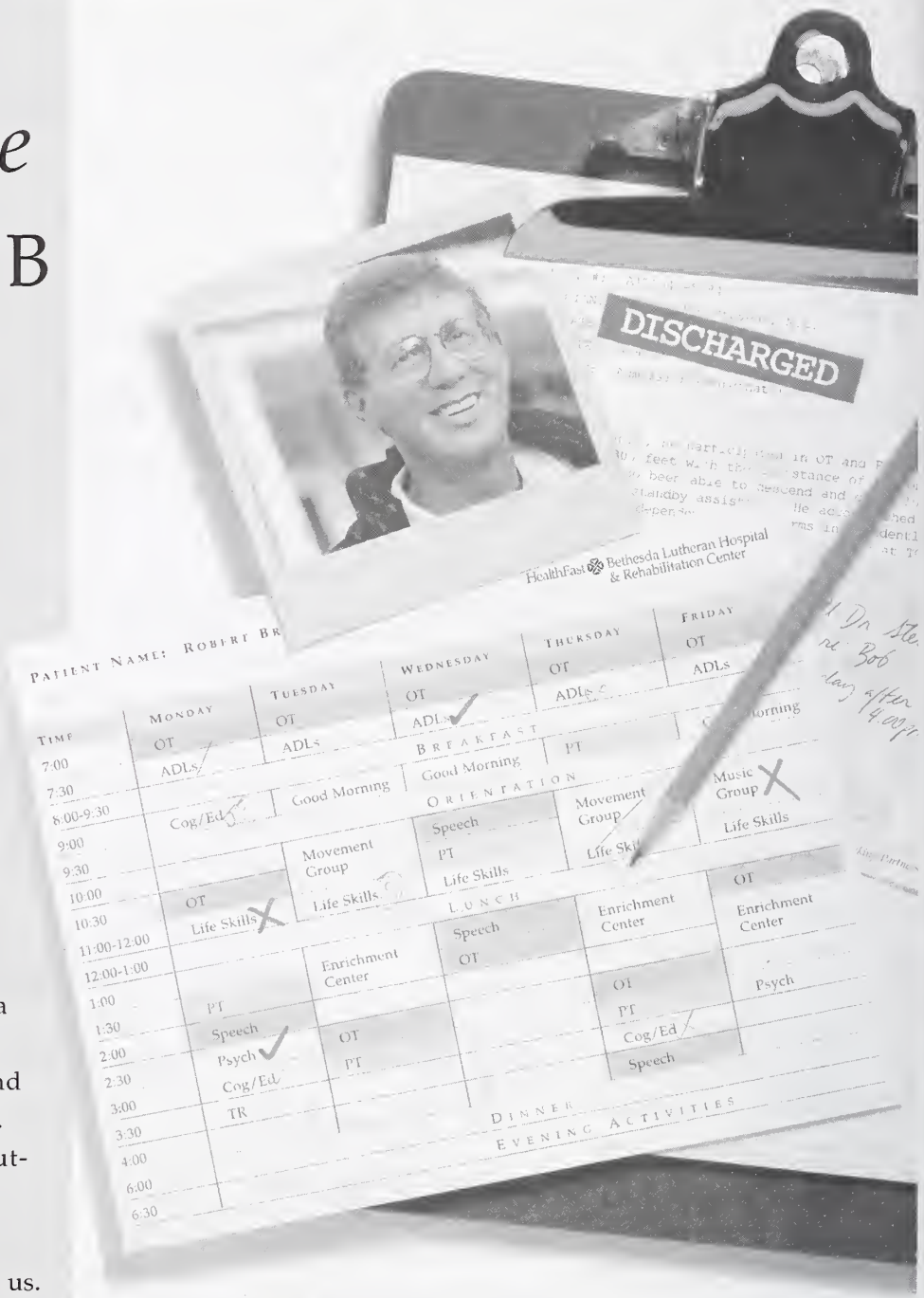
With unity and careful planning, we can continue to make a big difference in dealing with these issues. We must not let the fact that there are so many worthwhile issues to address overwhelm us. Doubts and even dissent are healthy and invigorating antidotes to stagnation. However let us conduct our discussions frankly, but in the spirit of cooperation always seeking solutions.

One of the greatest features of this organization is that we tend not to think alike. We are founded on diversity. It is unlikely we will resolve all differences. My goal is to appeal to the common good, the common interest, the medical and greater community concerns, the common cause. We are all in this together. Through unity and teamwork we can plan together then we can pull together. In order to consider all points of view. In order to remain open to suggestion. In order to reach honorable compromise. We need your input. Please feel free to express it. IM



HAROLD MILLER, MD
IMS PRESIDENT

A BUSY *Schedule* SENT BOB HOME *Early*



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New on the Net

Free legal info on the IMS web site

Check out the new law and regulation section on the IMS web site for legal information on medical records, billing issues and working with managed care organizations.

The complete Physician's Guide to Medical Records is now available through the new section as an easy desktop reference. Information about release and retention of medical records is now at your fingertips. You'll also find links to American Medical Association ethical opinions on medical records and other helpful legal sites on the Internet.

The Principles of Agreement for Managed Care is also now available through the IMS site. The Principles of Agreement was created as a blueprint to help physicians and payers deal with the growth of managed care.

The law and regulation section will continue to grow as a resource for Iowa physicians. The section is password-protected for IMS members only. Contact Sheryal Westbrook at 515/223-1401 or 800/747-3070 for your member password.

"Moving Toward the New Millennium"

Plan to attend the *1997 Iowa Health Care Information Expo: Moving Toward the New Millennium* on November 13 at the Embassy Suites Hotel in Des Moines. The conference is jointly sponsored by the Iowa Medical Society and the Association of Iowa Hospitals and Health Systems.

Among the meeting's topics are outcomes measurement, telemedicine, clinical decision-making support systems and electronic information transfer. Keynote speakers Jeffrey Bauer and Lawrence Week, MD will speak about the future of information and electronic resources in health care.

Meeting registration is available through the events section of the IMS web site.



Linking IMS physicians to the information they need

Hot sites

Health law resource: You'll find a wealth of legal information at the "Health Law Resource," a site created and updated regularly by an attorney specializing in health law. Topics covered on the web site include fraud and abuse, bioethics, privacy, Medicare/Medicaid and telemedicine. Each topic's page summarizes related controversial issues and points users to legal documents, articles and resources for researching health care topics.
www.netreach.net/~wmanning/index.html

Nature break: What else would you expect from National Geographic than pure excellence? Take a look at the nature society's site for a peek into what that Internet holds for the future. Graphics move smoothly and interaction is top notch, especially in the site's special feature on cats. The site is slow because of its extensive graphics, but you will be rewarded if you can stand the wait.
www.nationalgeographic.com

Medical information gateway: From the publishers of *Medical Economics* magazine comes a great site for medical research. "MedEc Interactive" is for physicians only and allows you to search a number of data bases and periodicals for the information you need. It even has an online PDR for easy access to drug information. *www.medecinteractive.com* IM

IMS staff members are on the watch for sites that might interest Iowa physicians. Staff members visit all **Hot sites** *to make sure they have useful information and reasonable download times. Suggestions for* **Hot sites** *can be sent to Melanie Finke by e-mail at mfinke@iowamedicalsociety.org or by telephone at 800/747-3070.*

Betting on a bright future

IMGMA Fall Meeting
October 22–24, 1997
Harvey's Hotel and Casino
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We are seeing lightning-speed changes in health care. But with careful planning and action, medical group managers can bet on a bright future. The IMGMA Fall Meeting will cover management education, strategic planning and legislative advocacy for medical group managers. Come and discover your options for creating a bright future for both patients and professionals .

Watch the mail for your registration forms coming in September

Featured Speaker



Preparing Your Health Care Delivery System for Success
Tom Royer, MD

Plus Special Topics Clinics, Medical Specialty Breakout Sessions, Panel of Payers and exhibits!

Physicians take the lead in Mississippi Valley IPA

(Eleventh in a series)

In July 1993, Burlington area physicians knew they needed to get organized in some way to address the potential impact of a Heritage National Healthplan expansion. While Heritage was the immediate cause for concern, the physicians realized they would be facing this type of managed care competition in the future.

MVIPA—a risk-bearing IPA

According to Tim Pella, clinic administrator at Orthopedic and Reconstructive Surgery Associates, PC in Burlington, the Mississippi Valley Independent Practice Association (MVIPA) was incorporated in September of that same year as a messenger model IPA for the purpose of reviewing and informing the membership of all managed care contracts within the area. Although originally organized as a messenger model IPA, the association is now closer to a true risk-bearing IPA.

Board and shareholders divide decision-making

An 11-member board of directors meets monthly and holds an annual shareholders' meeting as well as periodie special meetings as needed. Decision-making is split between board and shareholder responsibilities.

Michael McCoy, MD, a Burlington ob/gyn physician, is president of MVIPA. In a nutshell, Dr. McCoy is "responsible to the membership from the perspectives of contractual issue communication, member benefits, giving members the value for their dues dollar, market change awareness and in general, leading the board of directors in remaining proactive as our praetices change and there are more and more external influences affecting us."

What's in it for me?

IPA member advantages include contract review by the board and counsel, group purchasing plans, a community rating program for discount on professional liability insurance and enhanced professional relationships between the medical staffs of the individual communities.

High quality, cost-efficient health care

MVIPA's goals for the future are development and marketing of area-based small employer self-insured health plans; continuing enhancement of the member benefit package; retaining close working relationships between member physicians; and last but not least, continuing efforts toward assuring high quality, cost-efficient health care in southeast Iowa.

Patients in communities including Burlington, West Burlington, Ft. Madison, Keokuk and New London have access to approximately 80 physicians in 20 specialties including ob/gyn, anesthesiology, family practice, internal medicine, oncology, pediatrics, ENT, orthopaedics, radiology, general surgery, urology, pulmonology, neurology, cardiology, gastroenterology, ophthalmology, psychiatry, dermatology, podiatry and physiatry.

How to get started

On behalf of MVIPA, Tim Pella offers a lot of helpful advice for other Iowa physicians thinking about organizing to face future changes in the managed care arena:

- Recognize the need to organize. Seek outside expertise and form a task force of informed physicians of various specialties if it is necessary to bring the need to the physician community.
- Take a proactive approach to dealing with changes that come your way.
- Hire good, qualified health care counsel to assure your organization is developed appropriately within the regulatory framework.
- Develop a specific outline for the direction of your organization once it is formed. IM

"Recognize the need to organize and form a task force of informed physicians of various specialties."

KEY CONTACTS:

Mississippi Valley Independent Practice Association, Inc.
Burlington
319/754-8133

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Tim Pella
319/752-4553

Rob Poetting
319/754-4242

Amy O'Brien
Administrator
319/754-8133

If you know of other innovative practice arrangements we should write about in Iowa Medicine *— especially those controlled by physicians and positioned to compete in the managed care market — call Barb Cannon or Chris McMahon at the IMS, 515/223-1401 or 800/747-3070.*

With Kids And Diamonds,



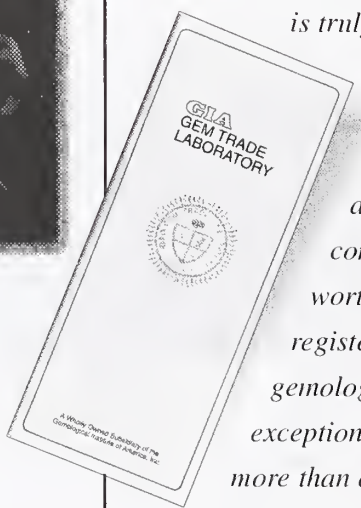


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IMS Update

There's help for litigation stress

In a joint effort with Midwest Medical Insurance Company (MMIC), the Iowa Medical Society has developed the Physician Litigation Support Program. The purpose of the program is to provide information and support to physicians experiencing stress related to the litigation process. September marks the debut of this program which is available to IMS members and MMIC insureds.

Twelve Iowa physicians from various specialties have volunteered to serve as one-on-one, confidential helpers. These physicians have all been through a claim or litigation process and also have taken specialized training on how to provide peer support.

A brochure about the program and a litigation stress booklet can be obtained by calling Lori Atkinson, MMIC risk management supervisor, at 800/798-9870 or 515/223-1482. Ms. Atkinson can also refer you to a physician colleague for emotional support.

News at a glance

The IMS and IH&HS are sponsoring the 1997 Iowa Health Care Information Expo on Thursday, November 13 at Embassy Suites, Des Moines. The joint conference will address such topics as information technology in health care in the next millennium and moving from memory-based to expert-based systems. Keynote speakers include Jeffrey Bauer, president of the Bauer Group from Hillrose, Colorado and Dr. Lawrence Weed, president of the PKC Corporation from Burlington, Vermont. There will be numerous break-out sessions and vendor exhibits. Meeting registration is available through the events section of the IMS web site.

Strategic planning updates

Any Iowa Medical Society member physician who would like to receive periodic updates on the IMS strategic planning process should contact Chris McMahon, vice president of communications at the IMS, 515/223-1401 or 800/747-3070.

Telephone interviews with physicians were held throughout the summer and a leadership retreat is scheduled for September.

(continued)

News from Iowa Medical Group Management Association (IMGMA)

Revisiting essentials of group practice

Honest self-assessment is crucial for health care managers trying to make it in what is a "pretty lonely job," said Kevin Hayden, FACMPE, executive vice president, Preferred Physician Partners, Ltd., at the Midwest Section Conference in Lake Geneva, Wisconsin.

Hayden indicated some of the personal and professional skills managers need today to prepare for tomorrow. Key points are knowledge of the health care industry, readiness to cope with and manage change, confidence in your abilities and those of your coworkers and honesty. Simply empowering employees and being a straightforward leader go a long way. Some skills come naturally, he noted; others need work. Hayden emphasized recognizing where your personal strengths lie so you can focus on developing areas of weakness. Hayden commented that all the skills in the world won't help if your role is not clearly established in the minds of physicians. You must have or be vested with responsibility, control and authority to succeed.

One of the worst things a manager can do is not develop skills they will need for future employment. Hayden said the number one quality desired in medical practice managers is leadership. Physicians are looking for people who can be leaders, not just managers.

Plan to attend the IMGMA fall meeting "Betting on a bright future" in Council Bluffs, October 22-24. Registration flyers were mailed in September.

(This article was written by Sue Marsh, office manager at Atlantic Medical Center and IMGMA vice president.)

IMS Update
continued

Focus on IMS Alliance

IMSA-sponsored legislation passes

The IMS Alliance's legislative efforts to include domestic violence language on marriage application forms and licenses has passed, but not without a fight.

On Mareh 26, HF174 passed out of the Human Resourees Committee on an 18-0 vote, but failed to get to the House floor for debate. A similar SF152 never made it out of committee. On April 15 we were advised it had not met the funnel date and was dead for the session. Then two days before the Iowa Legislature adjourned on May 31, Senator Naney Boettger from Harlan attached an amendment to HF612 on child support recovery to include the domestie violence language on marriage applieations and licenses. It passed both Houses on April 29 and was signed by Governor Branstad on May 21, 1997. Iowa is only the third state to include this language on marriage licenses.

The new marriage applieations and licenses will read as follows:

"The laws of this state affirm your right to enter into this marriage and at the same time to live within the marriage under the full protection of the laws of this state with regard to violence and abuse. Neither of you is the property of the other. Assault, sexual abuse, and willful injury of a spouse or other family member are violations of the laws of this state and are punishable by the state."

(This article was written by Cindy Ehrecke, IMSA president.)

Grand Forks flood contribution

The Iowa Medical Society is contributing $5000 to a fund created by the American Medical Association to help medical students and the University of North Dakota School of Medicine recover from the devastating April flood in the Grand Forks, North Dakota area.

The UND School of Medicine lost nearly $10 million in property and teaching equipment. Among its losses were its anatomy and microbiology laboratories, video equipment, the bookstore, a student lounge and a small group classroom.

The fund will also help the students recover from their personal losses. Nearly 135 medical students at the Grand Forks campus lost personal property when the city had to be quickly evacuated. IM

Specialty Society Update

The Iowa Association of Pathologists will hold its annual fall membership meeting October 17 in Iowa City. The membership will vote on recommended changes to the bylaws, which have not been revised since 1972.

The Iowa Association of County Medical Examiners board will meet Septemer 5 at Des Moines Golf & Country Club to discuss plans for the November 7 education and business meeting.

The Iowa Society of Rehabilitation Medicine will hold its annual fall membership meeting October 31 at IMS headquarters in West Des Moines.

The American Medical Directors Association, Iowa Chapter will hold its annual meeting September 12 in Iowa City.

The Iowa Psychiatric Society fall meeting honoring Dr. George Winokur will be held November 14-15 in Cedar Rapids at the Collins Plaza.

The American College of Cardiology-Iowa Chapter is making plans for its fall meeting on November 8th in Davenport.

Neurologist, Oncologist, Urgent Care . . .

There are immediate openings at Brainerd Medical Center for a Neurologist, an Oncologist and an Urgent Care physician.

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Brainerd, Minnesota 56401

University of Maryland

Legislative Affairs

Iowa delegation to attend conference

The 1997 AMA Political Grassroots Conference will be held September 17-18 in Washington, DC. This is a great opportunity to learn about legislative and regulatory issues affecting patients, physicians and the health care system.

The Iowa Medical Society is assembling an Iowa delegation to attend the conference. Call Paul Bishop, IMS legislative affairs manager, for more information.

State medical examiner rules

State Medical Examiner Tom Bennett, MD has proposed rules relating to the medical examiner system. The draft rules include deadlines for submission of medical examiner reports, standards for performance of autopsies, reimbursement for autopsies and training requirements for investigators. The Iowa Medical Society, Iowa Association of Pathologists and Iowa Association of County Medical Examiners submitted joint written comments and provided testimony at a public hearing.

According to the proposed rules, the state medical examiner would report violations of the rules to the state Board of Medical Examiners (BME). A report would first be made to the individual who violated the rules, the county medical examiner and the county board of supervisors. The individual would have 30 days to provide a response before a report is made to the BME. The IMS is concerned that the threat of being reported to the BME will deter physicians from serving as county medical examiners or performing medical examiner autopsies. In most counties, this is a voluntary public service with minimal reimbursement.

As of the press time, the rules were not final. For more information or a copy call Jeanine Freeman, vice president of public policy and advocacy, at the IMS.

News at a glance

Meetings continue on the Principles of Agreement for Managed Care. Several additional practitioner groups and insurers are participating in the talks. Issues to be discussed at the next meeting include utilization review and uniform claim forms.

The Iowa Department of Public Health has consulted with the Iowa Medical Society on possible rules governing stereotactic mammography. The IMS has identified a work group of surgeons and radiologists to advise the department on proposed regulations. A preliminary draft will be available in early fall for comment.

Medicaid managed care

The Iowa Medical Society submitted comments on a draft request for proposal for the state's Medicaid mental health and substance abuse managed care plans. The three-year contract currently held by Merit Behavioral Care will expire June 30, 1998. The state has begun preparations to receive proposals for the contract for the next three years.

The IMS also submitted comments this summer on administrative rules implementing new laws relating to certificate of need, the parental notification of abortion and scope of practice review committees.

Iowa BME needs peer reviewers

The Iowa Board of Medical Examiners (BME) is recruiting physicians to serve on its peer review committees. Licensed physicians board certified in anesthesiology, emergency medicine, internal medicine, family practice, ob/gyn, surgery or psychiatry are strongly encouraged to apply.

If you are interested in serving as a peer reviewer, please send a letter and copy of your CV immediately to: Peer Review Selection Committee, Iowa Board of Medical Examiners, 1209 East Court Avenue, Executive Hills West, Des Moines, Iowa 50319. For further information, contact Ann Martino, executive director, at 515/281-5171. IM

Medical Economics

News at a glance

HCFA Regional Administrator Joe Tilghman has notified the Iowa Medical Society that the GMIS pilot deadline has been extended 90 days. Data on the pilot is now expected during November 1997. The GMIS pilot is testing commercial software designed to edit the accuracy of provider billings to Medicare.

Medical liability reform measures—most importantly a cap on noneconomic damages—could save the Medicare program $480 to $800 million over the next five years, according to a Barents Group/KPMG Peat Marwick study. The House of Representatives passed Medicare reform legislation on June 9 which included a $250,000 cap on noneconomic damages in medical malpractice lawsuits. The House language, however, was dropped from the final bill.

Medicare budget reconciliation

The House, the Senate and President Clinton agreed to final language for HR2015, the Balanced Budget Act of 1997. The Act's provisions reflect its goal—to achieve a balanced budget by the year 2002.

Key provisions affecting physicians and the delivery of health care include:

• ***Allowance of Medicaid rates for cost sharing for qualified Medicare beneficiaries who are dual eligibles as payment in full***—This provision impacts the most needy (and the most expensive to care for) of all Medicare beneficiaries and can mean as much as a 20% reduction in payments for physician services to dual eligibles. Iowa physicians can expect to see a change since Iowa is one of those states that has paid the cost-sharing amount at the higher Medicare rate.

• ***Deadline for implementation of a new practice expense methodology extended to January 1999***—HCFA must recognize all physician practice expenses, gather new data, conduct further analysis, involve physicians and provide a 90-day comment period prior to implementation of the changes. New practice expense values will be phased-in over a four-year transition period, with full implementation in year 2002. A non-resource-based physician "down payment" provision caps practice expense costs for certain physician services at 110% of work costs. This change shifts $390 million from non-primary care procedures to fund a 6% increase in primary care office visits. Ophthalmology, orthopedic surgery and cardiothoracic surgery are most negatively impacted. This provision likely will be reconsidered by the end of the year.

• ***Physician payment reduction***—This was limited to $5.3 billion over five years (considerably less than prior proposals). Single physician conversion factor for 1998 is $37.13.

• ***HIPAA fraud and abuse***—These provisions remain intact, Medicare/Medicaid exclusionary authority is increased and civil money penalties are added for violations of the anti-kickback statute. Other onerous fraud and abuse proposals were defeated.

• ***State Children's Health Insurance Program***—Matching federal funds of $48 billion (partly-funded by an increased tax on cigarettes) will be allocated to the states over 10 years to support children's access to health care. Eligible children include those without insurance and in families with incomes below 200% of poverty. States must develop a plan within the options set forth in the legislation. Funds are available after October 1,1997. Grant monies also are available for treatment of type I diabetes in children.

IMS/Geographic Coalition score success

The IMS, working with the Geographic Coalition, was successful in achieving a more equitable Medicare reimbursement system from Congress. At issue was how Medicare pays managed care plans to provide care to the elderly under its AAPCC rates.

In 1998, a minimum floor will increase payment in 85 Iowa counties. By 2003, rates will be a blend of 50% national and 50% local. All areas are guaranteed a 2% annual increase.

The Geographic Coalition is a nonpartisan coalition of 24 state medical associations striving for equitable Medicare reimbursement by reducing the geographic variation in fee-for-service and managed care payment rates. IM

University of Michigan

DATA & TECHNOLOGY

IMS/IH&HS outpatient data base

Since 1995, the IMS and the Association of Iowa Hospitals & Health Systems (IH&HS) have been partners in development of an outpatient data base. Physicians who voluntarily submit data are realizing many benefits.

The development of the outpatient data base was originally a logical progression of IH&HS's highly successful inpatient data base. The outpatient data base was designed to collect information on procedures performed in an outpatient setting: principal procedure codes, diagnosis codes, city of residence, payment source, physician identifier, charge information, etc.

It became evident that one vital piece was missing from the hospital outpatient data base—some of those procedures were also being performed in physician offices. Unless physician office data was also captured, the outpatient data base would have limited value.

IH&HS invited the IMS to promote and encourage physicians to voluntarily submit data on certain procedures performed in clinics and/or ambulatory surgical centers. Physician representatives have since been involved in the further development of the data base.

It's easy to submit data

Submission of data is very easy. Your software vendor may be able to write a simple program to download to a disk the required information whenever a procedure that is part of the outpatient data base project is performed in your office. If this is not possible, IH&HS provides a free software disk that prompts your office staff on the necessary information about the patient encounter. This disk is then mailed to IH&HS.

The outpatient data base has been expanded to include more procedures performed in physician offices or ambulatory surgery centers. These include: myringotomy, carpal tunnel release, T & A, colonoscopy, bronchoscopy, sigmoidoscopy, vasectomy, breast biopsy, certain eye procedures, cardiac stress test, echocardiology and others. More procedures are added every year, and your suggestions are always welcome.

Reports determine market share

In return for submission of data, physicians will receive many useful reports. The primary report is a study of where your patients receiving these treatments come from by zip code (origin) and where patients living in your community go for these procedures (destination). This report serves as an excellent source to determine market share for your practice versus other physician offices or the hospital outpatient department.

For a minimal fee (usually less than $50), physicians may order customized reports. Comparisons can be made of your charges to other physicians or hospitals. You can monitor the trend of certain procedures being performed more in physician offices and less in hospital outpatient departments. The uses of the data base are limited only to your creativity and the amount of data in the data base.

The IMS encourages physicians to submit data to the outpatient data base. Incidentally, this project contributed significantly to the CHMIS decision that physicians not be required to submit electronic insurance claims. Since the data base becomes more valuable and useful as more data is collected, your participation becomes critical. IM

The IMS encourages physicians to participate in development of a statewide outpatient data base. Submission of data is easy and participating physicians receive several useful reports.

For more information, call Ed Whitver, vice president of administration, 515/223-1401 or 800/747-3070.

Practice Management

News at a glance

The AMA is encouraging member physicians to report problems they are encountering with health plans. The AMA wants to document what's going on as well as provide representation to member physicians and local medical societies. If you believe you have an unscrupulous health plan contract, report your situation to one of the following: Carol O'Brien, division director, 312/464-4367, e-mail Carol_OBrien@ama-assn.org; Helen Jameson, assistant director, 312/464-4271, e-mail Helen_Jameson@ama-assn.org or AMA Division of Representation, 515 North State Street, Chicago, Illinois 60610, fax 312/464-5846.

They have arrived!

Single organ system exam criteria are now available after being blessed by the AMA, HCFA and CPT. The new guidelines are effective October 1, 1997 with a grace period until January 1, 1998.

Exam criteria is available for cardiovascular, ENT, eyes, GU female, GU male, hematologic/lymphatic/immunologic, musculoskeletal, neurological, psychiatric, respiratory and skin. Any physician can use single organ system criteria if applicable, regardless of specialty. The general multisystem criteria have also changed. These criteria will change the way physicians document their physical exam to support E & M codes for Medicare and other payers.

IMS is recommending that affected specialties begin using the new criteria October 1. Primary care providers may find it more practical to wait until the January 1 deadline.

Barb Cannon and Barb Pierce, IMS practice management staff, will present the new guidelines over the ICN during the fall. Watch your mail for further details.

"ABCs of Compliance" program a success

During June and July, the "ABCs of Compliance" programs were held at 12 locations across Iowa and were well attended by physicians and staff wanting a practical approach to implementing a compliance program. Although compliance activities may need to initially focus on billing and CLIA issues, participants learned the comprehensive scope of compliance plans. Participants also appreciated the hands-on exercises which alerted them to actual compliance issues that have occurred in Iowa. Most commented that with the IMS approach, they could have a compliance program in place quickly.

E & M rap group hits the road

The summer E & M rap groups were attended by office personnel in coding , auditing and management positions. Internal auditing and monitoring were discussed and the HCFA documentation guidelines reviewed. These groups will continue to meet quarterly.

If you missed this rap group and want to attend the next one, fax your name, address, phone and fax number to Barb Pierce, 515/223-8420. IM

Practice Management Workshops for You

Retirement Planning for Physicians & Spouses

October 16 St. Luke's Hospital, Cedar Rapids
October 23 Mercy Medical Center, Mason City
October 30 St. Luke's Regional Medical Center, Sioux City

Retirement and estate planning are relevant topics for everyone at all career stages. Instructor: Jerry Foster, Foster Capital Management, Inc.

Health Insurance Overview

October 7, Mason City
October 28, Cedar Rapids

Medical Terminology

October 15, West Des Moines

ICD•9•CM Coding

October 29, Sioux City

For more information or to register for any IMS practice management workshop, call Sherry Johnson at IMS Services, 515/223-2816 or 800/728-5398.

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Breaching patient confidentiality: easier than you think

A physician recently recalled: "I had arrived early for a lunch date with a friend—a psychologist—and was siting in his reception area when the telephone rang. The machine picked up and I could hear the greeting message. Suddenly I heard the caller leaving a message about her daughter's appointment to talk about her anorexia and I realized to my shock that the caller was a friend of mine and her daughter was a friend of my son! I got up and turned the volume off. What were the odds that out of all the people who could call all the psychologists in this city, I would end up hearing a confidential message from someone I knew?"

This physician understood the gravity of the breach of confidentiality that had occurred and would not reveal to anyone what she had overheard. Breaching a patient's confidentiality is more than a malpractice issue. Confidentiality is the cornerstone of the physician-patient relationship; the basis of your patients' trust in you. Its breach can destroy that basic trust, leading not only to a potential lawsuit but to a loss that cuts physicians even deeper—the loss of a patient's confidence.

Here's how to protect patient confidentiality and prevent a potential lawsuit:

- Educate your staff about appropriate and inappropriate disclosure of patient information.
- Ensure all telephone calls about patient medical information take place in a private area.
- Beware of using answering machines to leave messages for patients. Keep messages generic.
- Be alert to unattended computer monitors. Never leave patient information displayed.
- Implement a policy on release of medical records and disclosure of patient information.
- Ensure appropriate safeguards are followed when faxing patient records. Confirm receipt by having the party fax back an acknowledgment for your records.

Take time to evaluate your clinic practice now and prevent a breach of confidentiality tomorrow. The malpractice claim from such a breach could cost you a precious commodity—the confidence and trust of your patients.

For more information contact Lori Atkinson, MMIC risk management supervisor, Midwest Medical Insurance Company, West Des Moines Office, PO Box 65790, West Des Moines, Iowa 50265; 800/798-9870 or 515/223-1482.

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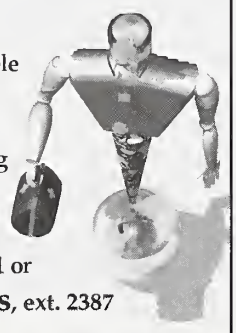
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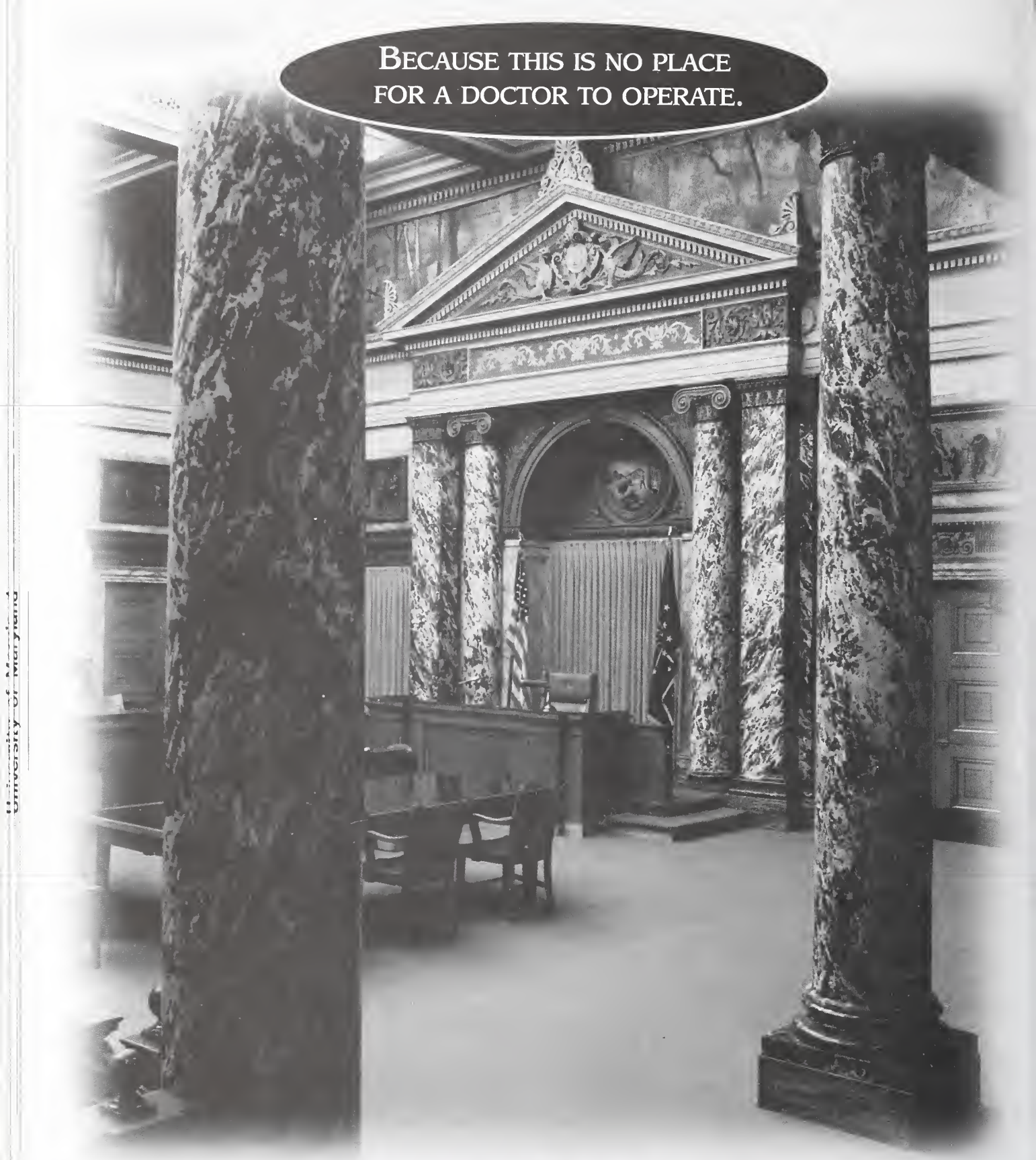


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Newsmakers

Awards, appointments, etc.

The following former clinic sites and services are now located at the Children's Health Center, 1212 Pleasant Street in Des Moines: Blank Center for Health, Blank Clinic, Blank Specialties Clinic, Children's Hospital physician billing and business office, Family Ecology Center, Pediatric Partners and pediatric surgery. McCrary-Rost Clinic, with offices in Lake City, Rockwell City and Lake View, has joined the McFarland Clinic system. McCrary-Rost physicians now practicing with McFarland Clinic are: **Drs. Donald Skinner, James Comstock, Linda Iler, Ted George, Paul Knouf and Paul Stebbins.** Central Iowa's first female plastic surgeon, **Dr. Marie Montag**, has joined Heartland Plastic and Reconstructive Surgery, PC, Des Moines. Dr. Montag specializes in pediatric and craniofacial reconstructive surgery. Genesis Medical Center (Davenport) physicians, **Drs. Hans Zinnecker**, general surgeon; **Richard Carruthers**, anesthesiologist and **Thomas Gellhaus**, obstetrician/gynecologist spent two weeks providing medical care to the residents of the Dominican Republic. State Medical Examiner **Dr. Thomas Bennett** travelled to Guam at the request of the National Transportation Safety Board to help investigators look into the crash of Korean Air flight 801. Dr. Bennett gained experience in this type of crash when he led autopsies of the crash victims of the 1989 United Airlines flight 232 in Sioux City. **Dr. Samuel Porter**, former senior vice president/chief medical officer and retired Mason City Clinic surgeon, was awarded the Sister Mary Maurita Sengelaub Award for Meritorious Service during a special ceremony at the 1997 Mercy Health Services Leadership Assembly. **Dr. Deborah LaBeau** has joined Dubuque Ob/gyn. She previously practiced at Keller Army Community Hospital in West Point, New York. **Dr. Glenn Harman**, oncologist, has joined Dubuque Internal Medicine. **Dr. Daniel Fabiano**, orthopedic surgeon, has joined Physicians Clinic of Iowa, Cedar Rapids.

News at a glance

The Cedar Rapids Medical Education Program has received a three-year federal grant totaling $426,226 to develop and implement a medical informatics curriculum for teaching young family practitioners. The curriculum will be developed at Cedar Rapids Family Practice Center located at Mercy Medical Center.

Dr. Julian Bruner, pioneer hand surgeon from Des Moines, died June 20. Dr. Bruner developed the Bruner table for hand surgery and was one of the first to recommend the use of surgical binoculars. Perhaps his most famous contribution to hand surgery was the zig-zag incision which is now routinely used in medical practice and taught in medical schools worldwide.



IMS President Dr. Harold Miller (center) is pictured with Dr. John Seward, AMA executive vice president (left), and Dr. Richard Corlin, speaker of the House of Delegates (right), at the AMA House of Delegates June meeting. Dr. Miller accepted an AMA award on behalf of the IMS for 21 consecutive years of increasing AMA membership among IMS members. Only one other state medical society has a longer record than the IMS—North Carolina.

Deceased members

Elmer Bean, MD, 75, life member, pediatrics, Fort Myers, Florida, died March 9

Howard Beatty, MD, 90, family practice, Creston, died March 3

Julian Bruner, MD, 96, life member, general surgeon/hand surgeon, Des Moines, died June 20

Hyman Hurevitz, MD, 94, life member, occupational medicine/internal medicine, Davenport, died June 4 IM

On the road to financial success . . .

Finishing STRONG



Faced with the looming uncertainty of the medical environment, Dr. Buddy Nichols found himself considering his future and evaluating his financial picture. "In 1993, I was feeling like I had done a pretty good job of accumulating assets, but there was something gnawing at me. I just didn't know for sure where I stood regarding my financial future. I had to do something."

That's a common attitude among physicians today. Where do they turn, and how do they get started? Dr. Buddy Nichols sought the advice of Foster Capital Management (FCM), a team of financial professionals endorsed by the Iowa Medical Society. FCM provides comprehensive financial planning and investment management on a fee basis. We recently discussed physicians and financial planning with Jerry Foster, Mark Stadtlander, Phil Kruzan, and Reed Rinderknecht of FCM.

IM: What is unique about physicians and the services you provide to them?

JERRY: Actually, physicians aren't unique from our other clients in their overall desires and objectives, but they offer special challenges today as a result of the many changes in the medical environment. With managed care becoming so prevalent, many groups are merging or are being acquired and this has created a tremendous amount of uncertainty. Many physicians are dealing with the possibility or certainty of reduced income and loss of control. Combined with a continual increase of government requirements, many are evaluating the possibilities of an earlier retirement. This requires planning and a disciplined strategy.



Phil Kruzan (left) and Reed Rinderknecht

IM: What are they doing to plan for retirement?

JERRY: That's one of the major problems we see in working with physicians. They know they should be planning, but most haven't taken the time to do it. The bottom line is that they are too busy to pay attention to their money or to establish any kind of strategic plan. I heard one doctor say, "I see 45 patients a day. I take no coffee break. I barely have time to go to the bathroom. It's like being on a treadmill."

REED: Once they do take the time to look at their financial picture, then there's the issue of figuring out how to wade through the constant barrage of what we call "media noise." There's no shortage of people who see themselves as experts in the areas of financial planning and investment management. These so-called "experts" are ready to give their

Jerry Foster, Phil Kruzan, Mark Stadtlander and Reed Rinderknecht are with Foster Capital Management, a fee-for-service financial planning and investment management company located at IMS headquarters, West Des Moines, 800/798-1012.

opinion whenever asked or even when they're not asked. The trouble is that you can pick up any paper or magazine and see two opposite views and everything in between. With financial issues being as complex as they are today, it puts the physician in a serious dilemma.

IM: Then how do they know when they are hearing the truth?

REED: That's the problem. We don't think anyone really can predict where the markets are going and what's the next hot ticket. Everybody in our industry would like to convince the consumer that they have a better mousetrap and superior research and development, when in reality, everyone is working with the same information and making predictions based on pure conjecture.

IM: So then, how is the consumer supposed to know how to move forward?

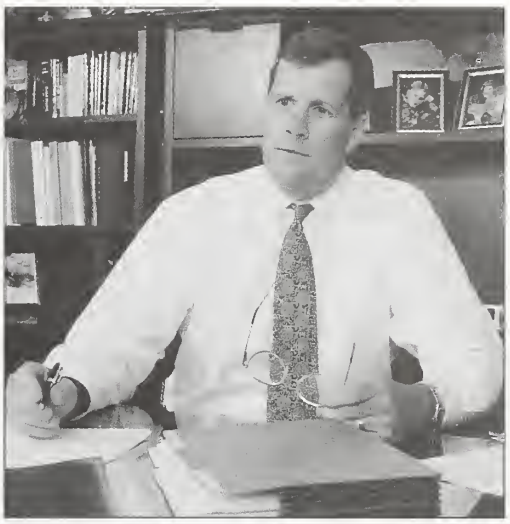
JERRY: It really becomes an issue of a fundamental and philosophical approach to investing and financial planning. From our perspective, it's an issue of integrating the various steps of financial management. In order to accomplish your personal objectives, you have to begin with a well-developed financial plan.

IM: What's involved in the financial planning process?

PHIL: We like to look at financial planning as having three distinct phases that all require different levels of direction and participation. The first is the accumulation phase. In this phase, we establish the goals and objectives and put a number of action steps in place which will ensure the accomplishment of the desired accumulation.

The second phase is the management process. In this phase, we evaluate the best way to manage the assets the client is accumulating. This will entail a properly written investment policy and a strategy for implementing it in the most-cost effective and tax-efficient manner.

Lastly, we enter the distribution phase. This is probably the most complex part of the planning process. Distribution takes on two different strategies. The first is the distribution of the assets during retirement. By the time a person reaches retirement, it is very likely they have accumulated a significant nest egg that will require some planning for income in order to minimize taxes. Putting the various income sources together into a structured and concise plan is critical to avoid what we call "accelerated capital spend down."



Physicians know they should be planning. The bottom line is that they are too busy to pay attention to their money or to establish any kind of strategic plan.

—Jerry Foster

Once a retirement income distribution strategy is established, the planning takes on a different look as we investigate ways to ensure that the distribution of what's left when the client dies goes in the desired direction. When we die, most likely an estate tax will be due. We like to refer to this as a "social tax." If creative planning has taken place, then the client can be involved in directing that social tax the way they want it to go rather than it all ending up with the government.

IM: When should a person begin this kind of planning?

PHIL: It's never too early to start thinking about what you would like to have happen. If you're involved in an ongoing planning process, you can systematically begin implementing the proper processes when the time is right.

JERRY: Getting involved in estate planning is really where the fun begins. If you stop and think about it, you spend your whole life building a career and a name for yourself. With creative planning, you can create a lega-

cy that lasts way beyond your own life and it can be a legacy that represents who you are and what you stand for. What more could a person want as a way to complete the whole life cycle?

IM: What other issues are physicians facing in the management of their money?

MARK: They expect too much from their investments. Most people determine what an acceptable rate of return for their portfolio should be based upon what Reed referred to earlier as "media noise." They listen to what's going on now in various markets and decide that they want the same kind of return going forward. We call this "rearview mirror" investing. They may have seen spectacular returns in their portfolio over the past period of time or have heard about some speculative investment from a colleague and then maintain or develop unrealistic expectations going forward. By integrating the planning process into the decisions regarding their investment strategy, we can develop a portfolio that has a realistic expectation that will meet the needs of the client.



We build portfolios designed to capture the efficiencies of the markets. It is our job to build portfolios where we can be highly accurate in predicting the volatility of a portfolio. *—Mark Stadtlander*

IM: Well, how can you develop a realistic expectation if you don't know what the markets are going to do?

MARK: We develop our strategies for our portfolios based on studies which have shown that 94% of a portfolio's return is attributed to the asset allocation. Only 4% is due to security selection and 2% to market timing. If asset allocation is what really makes a difference, then that's where we want to spend our time. The key is allocating the portfolio in such a way as to meet the required return as determined by the financial plan and keeping the portfolio allocated in the various asset classes so as to keep the volatility within acceptable parameters for the client.

IM: How do you effectively invest in all of the asset classes?

MARK: We don't attempt to purchase individual securities across all of the asset classes. We think it makes sense to utilize managers for each of the asset classes. The best way to do this is to use no-load mutual funds.

We use index funds and some institutional fund managers that by prospectus can only buy stocks from that asset class. This allows us to capture the efficiencies of the markets and get the desired outcome we're looking for in our overall strategy.

IM: How would you summarize the financial planning/management process in which physicians should participate?

JERRY: Don't procrastinate! That's the number one reason people fail to achieve their objectives. From there, the key ingredients to a successful financial strategy are as follows: First, quantify your goals and objectives. Put them down on paper. Do a little dreaming, but know what you are shooting for. Second, establish a strategic plan for achieving those goals. Know what the variables are and how each can affect the outcome of your planning. Third, implement your strategy. A great plan is worthless if it sits on a shelf and no action is taken. Fourth, monitor the progress of your planning and make necessary adjustments to ensure its success. Lastly, set some parameters and maintain discipline. Don't get sucked into some get-rich-quick scheme. Likewise, when markets are correcting, don't panic. A structured and disciplined strategy will help you hold the course and success will be imminent. IM

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"Et tu, Brute"

On the Legal Front

Physicians are required by Iowa law to report negligent or careless acts or omissions of their colleagues to the Iowa Board of Medical Examiners. AMA Ethical Opinion E-9.031 also requires the reporting of impaired, incompetent or unethical colleagues but generally directs initial reports to internal sources of redress, such as a hospital's impaired physicians or peer review committee.

What is a physician's reporting responsibility? Physicians having firsthand knowledge of acts or omissions of a colleague must report to the BME. Incompetency, impairment, fraud, unethical conduct and other acts or omissions for which a physician can be disciplined by the BME are reportable events. "Firsthand knowledge" is not specifically defined. Dictionary definitions say it is knowledge acquired directly from the original source. Even though a physician may not directly observe the event, reporting nonetheless may be required where enough information from reliable sources (i.e., patients, clinic or hospital personnel) gives rise to the reporting responsibility.

At what point must a report be filed? Reports are to be filed within 30 days of the date on which the physician acquires the information. AMA Ethical Opinion 9.031 indicates that a report to the licensing board is not required unless corrective measures are ineffective, or an immediate threat to the health of patients exists, or unethical conduct in violation of state licensing requirements is involved. The BME, however, may take a different view. To date, the BME has disciplined (by formal reprimand) only two physicians, both for failing to report firsthand knowledge of a colleague's impairment for over a year.

Are there exceptions to reporting? Yes, reports are not required where information is protected by the physician-patient relationship or where release of such information is prohibited by state or federal statute.

Are reports confidential? Complaints, including the reports, are confidential while in the investigatory stages. Upon the filing of a statement of charges, however, the report is released to the subject physician upon request for defense purposes.

What if a physician fails to report? Physicians failing to report can be disciplined by the BME.

Physicians having firsthand knowledge of acts or omissions of a colleague must report to the Board of Medical Examiners.

Can a physician be sued for reporting? For failure to report? Reporting physicians are granted statutory immunity from civil liability except where the report is filed with malice. The law does not provide similar liability protections against allegations by an injured patient that a negligent physician continued practice because of a failure to report.

Next month's article will focus on reporting of impaired physicians and the BME's Impaired Physician Review Committee. IM



Jeanine Freeman, JD

The information in this column in not intended to be legal advice. If you have specific questions or concerns, contact your attorney.

Ms Freeman is vice president of public policy and advocacy at the Iowa Medical Society.

Mercy Hospital Medical Center

presents

"CLINICAL UPDATES '97: THE CUTTING EDGE"

Wednesday, October 22, 1997

Guest Faculty	Topics
Julian Solway, M.D. University of Chicago Pritzker School of Medicine Chicago, Illinois	**"Mastering the Art of Asthma Management"**
Stanley Birge, M.D. Department of Medicine/Geriatrics Washington University School of Medicine St. Louis, Missouri	**"Alzheimer's Disease: The Role of Hormone Replacement Therapy"**
Stuart Fine, M.D. Department of Medicine/Endocrinology University of Chicago School of Medicine Chicago, Illinois	**"Management of Diabetes in the 21st Century"**
Rick Turner, M.D. Mercy Psychiatric Services Consultation/ Liaison Service Mercy Franklin Center Des Moines, Iowa	**"Psychocardiology: Depression in Coronary Care"**
Charles Davidson, M.D. Department of Medicine Cardiac Catheterization Laboratory Northwestern University Medical School Chicago, Illinois	**"A New Era in Antiplatelet Therapies: Treatment of Unstable Angina"**
Hal Mardis, M.D. Department of Surgery/Urology University of Nebraska Medical Center Omaha, Nebraska	**"Benign Prostatic Hyperplasia: What Are the Options?"**

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The Journal
of the Iowa Medical Society

Prevention of subsequent coronary events

● JENNIFER ROBINSON, MD

Physicians now have the results of a number of large, randomized, placebo-controlled clinical trials to assist in their decision-making following the diagnosis of coronary artery disease.

In addition to a low fat diet, regular exercise and smoking cessation, several new therapies have been shown to improve overall survival by preventing subsequent coronary events.

Cholesterol-lowering

The Scandinavian Simvastatin Survival Study (4-S) published in 1994 conclusively demonstrated that lowering cholesterol levels in patients with documented coronary artery disease lowered all-cause mortality.[1] Patients receiving simvastatin 20-40 mg/day had a 30% reduction in total mortality over 5.4 years.

The reduction in death rate was entirely attributable to a reduction in coronary causes of death, with no increase in non-cardiovascular causes of death (e.g., cancer, suicides, accidents, etc.). Low-density lipoprotein (LDL) cholesterol was reduced by 35% to a mean LDL = 130 mg/dl. High-density lipoprotein (HDL) cholesterol also improved, with an 8% average increase.

Both women and persons over 60 experienced a significant reduction in mortality. According to current National Cholesterol Education Panel (NCEP) guidelines, all persons in otherwise good health should try to achieve an LDL cholesterol level of 100 to 130 mg/dl.

In addition to a low fat (Step II) diet and exercise, patients may also need an effective cholesterol-lowering agent such as simvastatin or another HMGCoA reductase inhibitor (statin). Use of statins has been shown to be cost-effective for patients with coronary disease.[2]

ACE inhibitors

Several recent studies have shown that angiotensin converting enzyme (ACE) inhibitors reduce cardiovascular morbidity and mortality by approximately 20% in patients who have had a myocardial infarction (MI) with symptomatic or asymptomatic left ventricular dysfunction (ejection fraction < 40%). ACE inhibitor therapy may begin the first day after MI if the patient is hemodynamically and clinically stable during careful observation and after administration of routinely recommended treatments (thrombolysis, aspirin, and ß-blockers).

Following a test dose of captopril 6.25 mg, oral captopril can be titrated to 25 mg t.i.d during the hospital course. Other ACE inhibitors can be used, but a small test dose should be given and then the drug should be slowly titrated up as tolerated. Recommended long-term dosages are captopril 50 mg. t.i.d., enalapril 20 mg q.d., or ramipril 5 mg b.i.d.

In patients with symptomatic heart failure post-MI, ACE inhibitor treatment should continue long-term. In patients with asymptomatic left ventricular dysfunction, ACE inhibitor therapy may be reconsidered after four to six weeks. Further assessment of left ventricular function might be considered at four to six months.

Aspirin

Unfortunately, community-based surveys have shown that aspirin is used in less than 50% of patients who are suitable candidates. Antiplatelet agents after MI, coronary artery bypass grafting, stroke, transient ischemic attacks or unstable or chronic angina have been shown to reduce subsequent cardiovascular events by 25% and all-cause mortality by 15-

The IMS Education Fund has designated this article as the Henry Albert Presentation Award for September 1997.

JENNIFER ROBINSON, MD
Dr. Robinson is an internal medicine specialist with the Preventive Cardiology Lipid Clinic, Iowa Heart Center in Des Moines.

Prevention of subsequent coronary events

continued

20%. The elderly experience similar benefits without excessive side effects. A dosage of aspirin 160 to 325 mg/d is recommended. Aspirin should be started immediately in patients diagnosed with coronary disease and continued indefinitely. For patients intolerant of aspirin, those with atrial fibrillation or those with a history of a prior embolism from a cardiac source, long-term therapy with oral warfarin can be considered.[3]

Beta-blockers

Similarly, beta-blockers are used in only 20-30% of suitable patients following an acute myocardial infarction. Long-term treatment with beta-blockers used after myocardial infarction reduces total mortality by approximately 20%, primarily due to a reduction in sudden death. Although beta-blockers are clearly contraindicated in some patients, most of these arguments do not warrant withholding beta-blockers from many patients. The effects on lipids appear to be only theoretical.

Patients with diabetes experience a greater benefit from beta-blockers than non-diabetics. Prolonged hypoglycemia appears to occur only rarely, especially when cardioselective beta-blockers are used.

Recent studies have shown that patients with past or present congestive heart failure also experience a significant benefit from beta-blockers, provided that the starting dose is extremely low and the drug is given with great care. Quality of life does not appear to be adversely affected, as was shown in several large, placebo-controlled studies. Nor does the presence of peripheral vascular disease appear to be a strong contraindication. Metoprolol 50-100 mg b.i.d. or atenolol 50-200 mg q.d., as tolerated, are both good choices in a wide range of patients.

On the horizon

Several randomized clinical trials are currently underway to determine the role of postmenpausal hormone replacement and antioxidants in the prevention of coronary disease. Of concern, two recent studies have shown excess cancer deaths in smokers receiving beta-carotene for lung cancer prevention. Therefore, beta-carotene should not be routinely used for prophylaxis. Vitamin E has generated a great deal of interest, but there was a small excess of hemorrhagic stroke in male smokers in one study, so it is prudent to recommend patients who want to take it not to exceed 200 mg per day.

Postmenopausal hormone replacement is being widely recommended to prevent coronary disease based on observational data. Estrogen replacement is useful for treating lipid abnormalities although breast cancer risk does rise after 8-10 years of therapy. Current practice is moving toward continuous estrogen and low-dose progestin therapy in women with a uterus, such as conjugated equine estrogen (Premarin ® 0.625 mg/d) plus medroxyprogesterone 2.5 mg daily.

References

References are available from the authors or the editors of *Iowa Medicine*. IM

Mercy Hospital Medical Center

presents

"WHAT MAKES US HUMAN?"

Wednesday, November 5, 1997

This program will present the personal and professional insights of five representatives from the disciplines of neurology, psychology, psychiatry, family medicine, and theology, as to "what makes us human". Each speaker will offer perspectives relative to his individual area of expertise and will encourage audience participation to stimulate further informal discussion of this interesting and controversial topic.

Guest Faculty	Discipline/Perspective

Fred Bahls, M.D. **Neurology**
Staff Neurologist
Department of Neurology and Psychiatry
Mercy Hospital Medical Center
Des Moines, Iowa

Raymond Moore, Ph.D.**Psychology**
Psychologist in Private Practice
Des Moines, Iowa

Rick Turner, M.D.**Psychiatry**
Mercy Psychiatric Consultant/Liaison Services
Mercy Franklin Center
Des Moines, Iowa

Reverend Larry Conrad**Theology**
Department of Pastoral Care
Mercy Hospital Medical Center
Des Moines, Iowa

Robert Bender II, M.D.**Family Medicine**
Director, Mercy/Mayo Family Practice
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As physicians, our hearts have always been with our patients. Our mission saving lives.

Once this was enough.

Today, however, we are called upon to save more than our patients' lives. We are called upon to save their rights as well.

That's why I'm asking you to support the American Medical Association (AMA) as well as your state and local medical associations.

Together, we can achieve real and lasting changes. Already we have made great strides on behalf of our patients. Working together, we are educating a nation about the dangers of "gag" clauses, developing patient protection measures, and launching a wide spectrum of public health initiatives.

During Women In Medicine Month, we gratefully acknowledge the participation and support of all our female members. The AMA now has more women physicians than any other medical association. We encourage all female physicians, residents, and medical students to become members. So please, join now. Your patients' future rights and your entire profession depend on your commitment today.



"Let's keep our commitment where our hearts are. Behind our patients."

Support your patients and your profession. Join the AMA, and your state and county medical associations.

Nancy Wilson Dickey, MD
President - Elect
American Medical Association

American Medical Association
Physicians dedicated to the health of America

Observations from the front porch

Another hot and humid day appears to be in the offing. As I sit on the front porch during the early morning hours a cool breeze has been replaced by warmer temperatures. It's going to be hot today. One of the rewards of retirement is to sit on the front porch with a second cup of coffee, watching the world go by.

Zoom! Zoom! Varoom! The traffic is increasing. The busy street becomes a veritable race track. I become engrossed in the many types of vehicles going by . . . speeding, small cars, large cars, red ones, black ones, white ones, some shining new, others a bit worse for wear.

The drivers become an object of my observation as well. Some appear very serious, gripping the steering wheel firmly and resolutely. Others are nonchalant, driving with one arm out the window. "Flip;" darnit, another cigarette thrown out onto the yard. It seems many drivers have no knowledge of an ashtray in their auto. Other drivers are talking on cellular telephones, others eating or drinking. Quite a number are sucking from water bottles; haven't they been weaned? It is laudable they are trying to increase their daily water intake. Some drivers are reading the morning paper or yakking at their kids (no seatbelt). Hey! Wow! Look at that beautiful young lady driving her red convertible. Every five seconds another car speeds by.

Something else catches my eye. On the front porch grillwork is a spider web. What a marvel of architecture wrought by such a tiny creature . . . a web developed through a wondrous ability designed to entrap a meal.

Oh, no! Look at that poor soul across the street making his way along the sidewalk. Slowly he trudges, one foot, then the other. Perspiration is apparent on his face; his shirt is drenched as well. Lanky limbs move him onward, though one would wonder if he will reach his destination. Is that healthful jogging? Others trot by at ease, older men and women, young men in obvious excellent physical state, girls lopping along with ponytails bobbing.

Another creature catches my eye—a robin hopping, stopping cocking her head to one side, obviously searching for a worm. For herself or for offspring in a nearby nest? Other birds are singing loudly attesting to how great this world is.

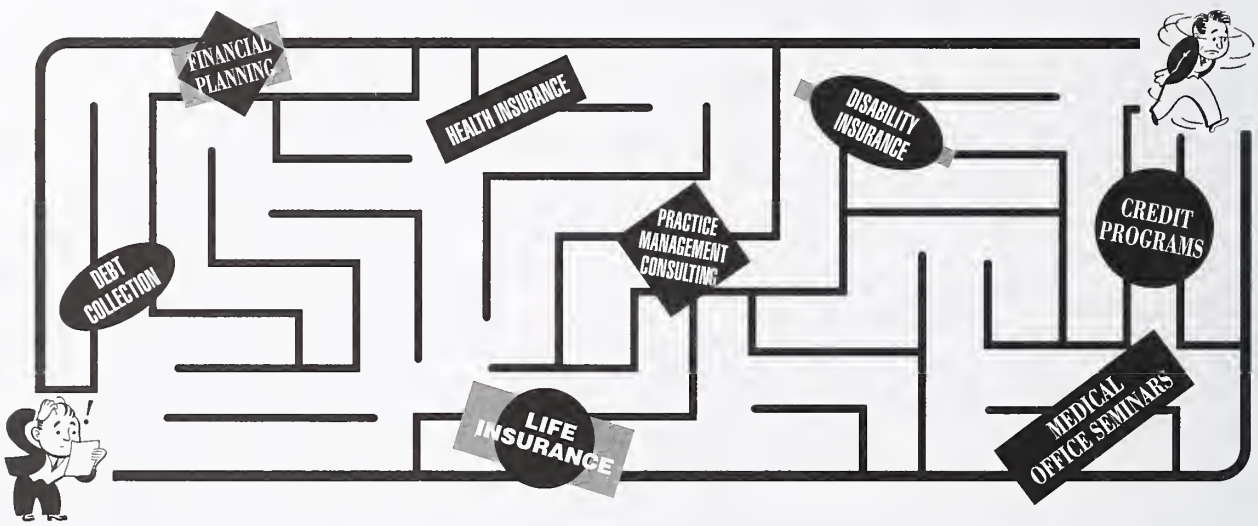
One of the rewards of retirement is to sit on the front porch with a second cup of coffee, watching the world go by.

Well, my coffee cup is empty. Even though retired, I do have other things to do, so my observations come to an end for today. There will be another day, another cup of coffee, more observations. How good it is!! IM



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The use of judgment in practice

Canadian physicians were surveyed recently about how they acquired knowledge for use in their medical practices. They cited, in rank order, the following CME experiences: consultation with a colleague, a sponsored CME course, regular journal reading and local hospital rounds.

If physicians most readily learn from their colleagues, how are the colleagues acquiring knowledge of innovations in care? The learning modalities cited, with the exception of journal reading, are passive: information is being transmitted in packages digested by others.

There is a current reaction among many physicians to resist the effort to standardize medical management by developing protocols. These physicians are convinced the variations in individual circumstances warrant the use of judgment that may contradict the recommendations within a protocol.

Is there an inherent conflict between preferred physician learning modalities and the justification for the use of judgment in practice? Lacking the absolute, unqualified knowledge of how to most scientifically manage a clinical problem, the medical profession has traditionally justified idiosyncrasy based on judgment.

The human mind has the immense capacity to sort items of information, including information acquired through experience, to reach conclusions and formulate action. Medical judgment is just that process. The physician, for example, may care for an elderly patient with a condition whose disease management protocol dictates the prescription of a medication to be taken four times daily. The physician, understanding the doubtful capacity of that particular patient to adhere to such a regimen, may elect to substitute another medication requiring only a single daily dose, even knowing that the efficacy of this latter medication is inferior to the preferred drug.

Judgment in this illustration revolves around a series of related facts or observations: the efficacy of two medications, the capacity of the patient to comply with a regimen, the acceptance by the physician and patient of different outcomes using one medication in contrast to the other.

The physician must utilize objective knowledge, experiental wisdom and live within acceptable ethical parameters.

The physician must utilize objective knowledge (here the efficacy of two drugs), experiential wisdom (here a prediction of compliance) and live within acceptable ethical parameters (the contrasting outcomes).

Protocol and judgment. Undoubtedly contemporary medicine lives with both phenomena. Protocols will march forward into practice with relentless frequency, but judgment will survive as long as physicians integrate new understanding with experience. IM



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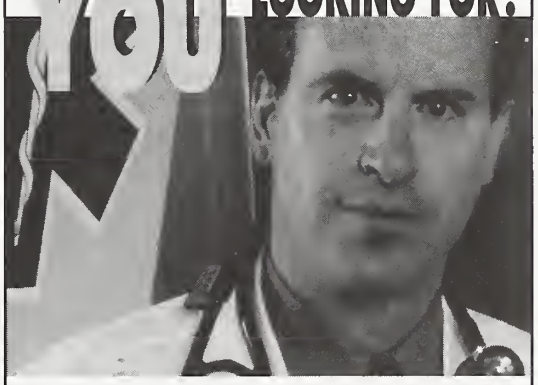
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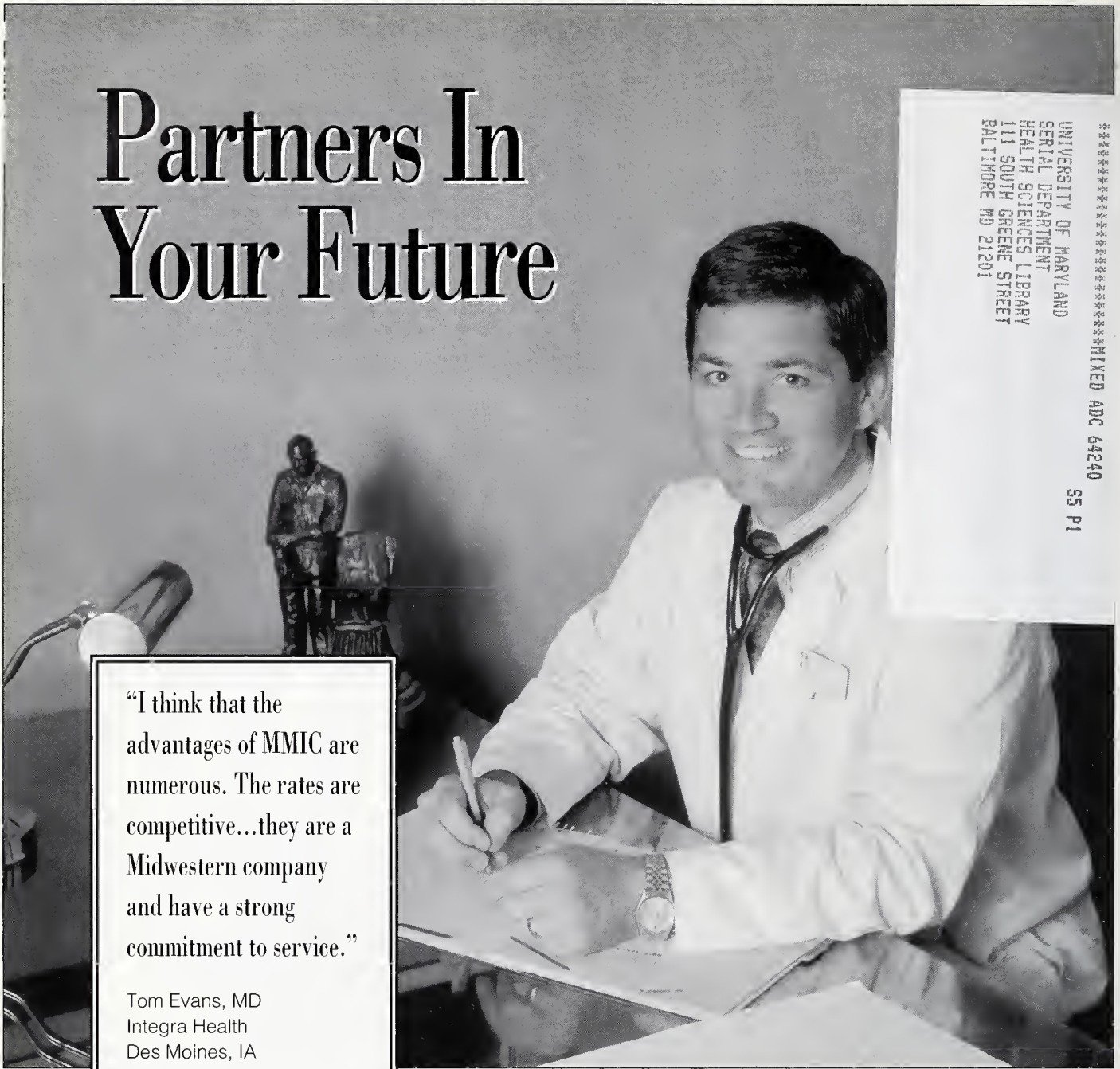
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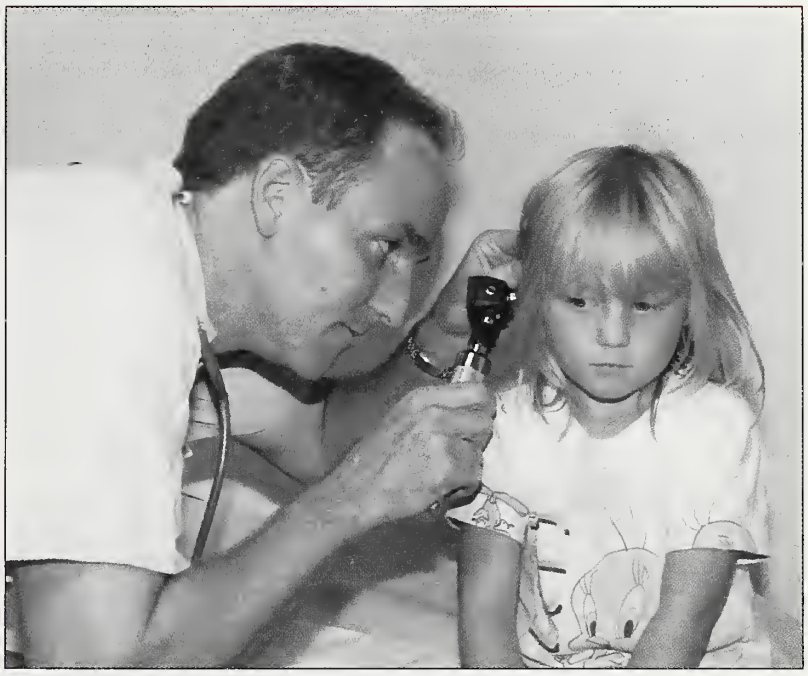
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Share your managed care stories with us . . . for details on how to submit a written account, see page 307

Physician, heal thyself

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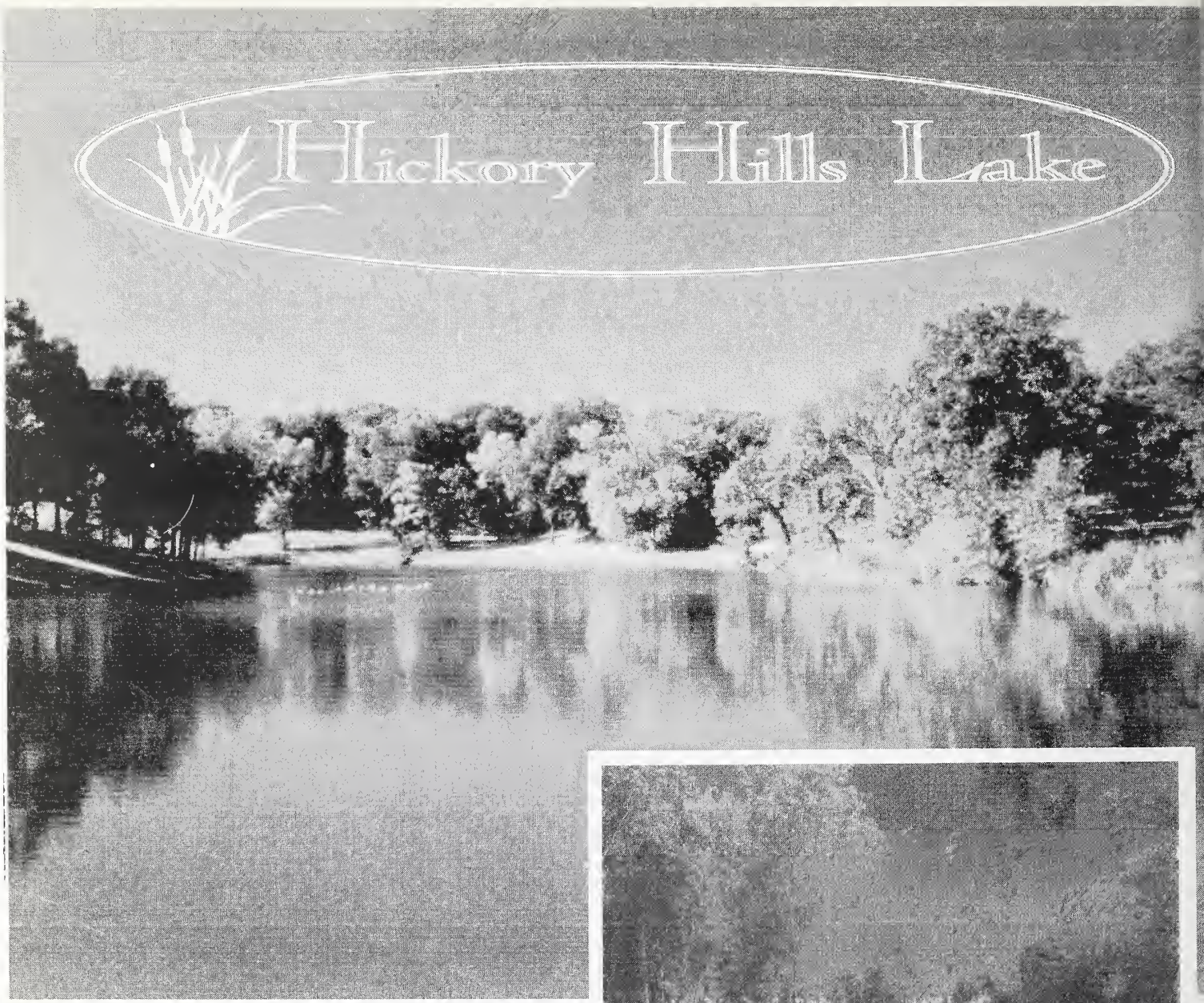
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STACKS

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IMS *DEADLINE* news

October, 1997

Late-breaking news of interest to Iowa physicians

•**THE FUTURE DIRECTION OF THE IOWA MEDICAL SOCIETY** was on the agenda at the first IMS strategic planning retreat last week. Physician members of the IMS, the Board of Trustees, Judicial Councilors and others representing key stakeholders such as clinic managers gathered for three days to discuss how the IMS can reinvent itself to better serve physicians in the new environment. Basic questions discussed by the group included: What is our core mission as physicians and as the organization representing physicians? AND, What core values are unchangeable, no matter how the environment changes? The IMS Strategic Planning Task Force will meet in November to begin determining how our core values and core mission shape the way IMS serves physicians. Retreats in January and February will deal with possible changes in the IMS governance structure to better meet the needs of today's physicians. IMS is assembling a list of physicians who wish to receive periodic updates on the IMS strategic planning process. If you wish to be included on this list, call Chris McMahon at the IMS.

•**IMS ALLIANCE COORDINATOR SANDY NICHOLS** is a recipient of the 1997 Governor's Award for Exemplary Service in Volunteer Leadership. She received her award at the Governor's Conference on Volunteerism in Des Moines in late September.

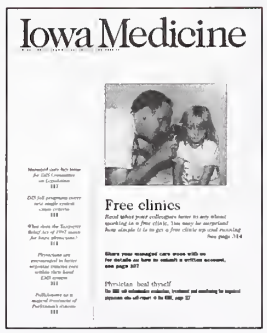
•**FALLOUT FROM THE AMA'S ILL-FATED SUNBEAM PROJECT** continued at press time. According to Reuters news service, the AMA's chief operating officer and two other top officers resigned September 20 after the AMA Board held an emergency meeting to review the marketing agreement with Sunbeam Corp. In a statement released by the AMA, Dr. Thomas Reardon, chair of the AMA Board, said, "The Board is reaffirming its commitment to the AMA values of professionalism, advocacy for the highest ethics and preservation of the patient/physician relationship." Reardon further stated that there was a "systematic breakdown" of the AMA's internal systems designed to ensure that arrangements with other entities are in accord with AMA policy and that "significant initiatives are brought before the Board for its approval prior to implementation." Executives who left their positions were Ken Monroe, chief operating officer; James Rappel, group vice president for business and management and Larry Jellen, vice president of marketing. Meanwhile, Sunbeam is suing in federal court because the AMA asked to be released from the deal.

•**IMS LEADERS VISITED WITH OUR CONGRESSIONAL DELEGATION** in conjunction with the American Medical Political Action Committee's 1997 Grassroots Conference. Gene Herbek, MD, chair of the Iowa Medical Political Action Committee, led the delegation in its discussions with Iowa's congressmen. Topics under discussion included Medicare contracting and the need for revisions to the language which says that physicians who enter into private contracts with Medicare patients can't participate in Medicare for two years. IMS representatives also spoke in favor of Dr. David Satcher's nomination for surgeon general and argued for inclusion of a physician on the National Bipartisan Commission on the Future of Medicare. The commission will determine the fate of Medicare and is the most coveted seat in Washington, DC. Unfortunately, there now is no specific plan to put a physician on the 15-member commission, though Iowa's congressional delegation responded favorably to the idea.

For more information about any *DEADLINE* news item, call Chris McMahon at IMS headquarters, 515/223-1401 or 800/747-3070.

Iowa Medicine

JOURNAL OF THE IOWA MEDICAL SOCIETY OCTOBER 1997 / VOLUME 87 / 8



About the cover

Dr. Mike O'Brien is pictured with a young patient at the Mae E. Davis Free Medical Clinic in West Des Moines. Read about other Iowa physicians who donate their time to set up free clinics and provide free medical care.

Editorial Board

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Feature Articles

Professional satisfaction and self-fulfillment 301

Physicians' professional freedom is challenged by managed care plans and Medicare rules. Is self-fulfillment an attainable goal? *Harold Miller, MD, IMS president*

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Discover Adobe Acrobat Reader and two hot sites—iPrint and WINGS.

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Free clinics 314

Physicians across the state are getting involved with free clinics. Setting up free clinics is simple, and caring for patients who can't afford medical care brings the joy back into practicing medicine. *Melanie Finke, IMS staff*

Statewide trauma care system update 321

The Iowa trauma plan and statewide trauma care system legislation have been geared to meet the needs of our predominantly rural population. *Timothy Peterson, MD*

Surgical treatment of Parkinson's disease 323

Pallidotomy has proven effective in controlling dyskinesia, bradykinesia and tremor.
Patrick Hitchon, MD; Kenneth Follet, MD; Pamela Schneider; Robert Rodnitzky, MD; Todd Ajax, MD; Judy Dobson; James Torner, PhD

Free rupture of a sinus of Valsalva aneurysm 326

Successful surgical obliteration of a ruptured aneurysm of the sinus of Valsalva results in dramatic improvement of symptoms as documented in this case report.
David Hockmuth, MD; Mark Nelson, MD; Steven Phillips, MD

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Tax Act of 1997 . . . a brief of relief *Jerry Foster* 319

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Professional satisfaction and self-fulfillment

We too often hear of our colleague physicians retiring from the active practice of medicine in the prime of their professional lives. Too often these are physicians whose skills are finely honed and whose abilities are sorely needed. Their professional contributions are significantly missed by other practitioners. These fine physicians leave practice frequently with the refrain that medicine "just isn't fun any more."

I've read dissertations on this subject, some stating medicine shouldn't be fun, others stating no profession can be fun, still others observing physicians leaving the profession early have forgotten why they entered medicine.

My understanding was recently improved while reading about professional baseball. The former president of Yale University and commissioner of baseball made the following statement in the prologue to his book on the world of professional baseball. The clearest definition of 'play' is as follows: "Play is free and self-fulfilling. This means the person is free to make choices and is rewarded by the participation."

Our professional work is not play and many will argue with the concept of whether it should be fun. Yet, most will agree physicians should be free to make choices and the practice of medicine should be self-fulfilling.

Our professional freedom is challenged by many things. Medicare rules state submitted diagnoses should not be nonspecific, even though the nonspecific diagnosis is the accurate diagnosis at the time of document creation. Managed care plans request our chronic prescriptions be for 31 or 90 days. Other managed care plans ask us to precertify all admissions to the hospital and if certified on the weekend they may be decertified on Monday morning. Surgeons tell of angry letters asking why they didn't seek precertification on emergency surgeries. Perhaps it is our common sense rather than our freedom that is under assault.

A recent *JAMA* article discussed decreased levels of professional satisfaction by primary care physicians in an individually capitated environment. To some extent this was due to the internal conflicts which can arise from that payment modality. To a greater extent it was due to a perceived lack of freedom to advocate for their patient's best interests.

I understand why a physician can be so bombarded he or she feels freedom is lost, and self-fulfillment is an impossible goal.

I understand why a physician can be so bombarded he or she feels freedom is lost, and self-fulfillment is an impossible goal.

IMS members must prevent the conversion of our professional services into a commodity. We owe it to our community. We must also prevent the erosion of freedom and the loss of self-fulfillment. We owe that to those who follow us in this profession. IM



HAROLD MILLER, MD
IMS PRESIDENT



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Adobe Acrobat Reader is not a huge file, but it will take you 10-30 minutes to download depending on the speed of your connection and the time of day. First thing in the morning, lunch and late afternoon are high-usage times on the Internet.

After you finish downloading the file, you will have to exit your browser program and install the software. When you finish installing Adobe Acrobat Reader, venture back out on the Internet to view and print the numerous PDF documents available.

One site that uses PDF documents regularly is the Health Care Financing Administration's site at *www.hcfa.gov*. Take a look under its Medicare information for professionals for a PDF of the new single system examination criteria. Program manuals for Medicare and Medicaid are also available in PDF documents through the HCFA web site.



Linking IMS physicians to the information they need

Hot sites

iPrint: Recommended by *WebMaster* magazine, "iPrint" is a great site for quick, economical and easy print jobs. Need 50 simple announcements to introduce a new physician to your practice? Try iPrint before turning to a more expensive commercial printer. You can choose among different papers, ink colors, graphics and nearly 30 typestyles to create the perfect printed piece. Design your piece online using a simple interface. Print out a copy to make sure you like how it looks, and place your order. Orders are processed and mailed in about seven business days. You can also save your designs for up to two years, making reorders of office stationery easy. One hint: take a look at iPrint's information section before you begin. *www.iprint.com*

WINGS: The "Web Interactive Network of Government Services" (WINGS) claims to make one-stop shopping for government customer service a reality. The site is a postal service effort to help local, state and federal governments provide the public with easy-to-use services that aren't organized along bureaucracy structures. The site's moving section guides the public to online forms for registering address changes with the post office and the Internal Revenue Service. You can also request a birth certificate or start an immunization record for a baby in the site's life change section. *www.wings.gov* IM

IMS staff members are on the watch for sites that might interest Iowa physicians. Staff members visit all **Hot sites** *to make sure they have useful information and reasonable download times. Suggestions for* **Hot sites** *can be sent to Melanie Finke by e-mail at mfinke@iowamedicalsociety.org or by telephone at 800/747-3070.*

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IMS Update

Focus groups reveal physicians' concerns

The Iowa Medical Society held focus group meetings this summer as part of the information-gathering phase of a comprehensive IMS strategic planning process. Thirty-six Iowa physicians attended the meetings which were held in Cedar Rapids, Des Moines and Storm Lake. The attendees represented a mix of specialties, ages, years in practice and gender. Both IMS members and nonmembers participated in the focus groups.

Physicians in the focus groups said they feel "powerless" when dealing with various third party payers. They also said they don't know where to turn for advice on issues in the new world of health care delivery—issues such as contracts and the pitfalls of being an employed physician.

Physicians are also extremely apprehensive about the government's much-publicized move toward stamping out fraud and abuse in the Medicare program. One physician commented: "I worry a lot about what I might be doing right now—something I'm doing innocently—that will get me into trouble later."

News at a glance

The Iowa Medical Society Board of Trustees recently met with representatives of the Iowa Association of Business and Industry (ABI). The two groups discussed the successful effort made by the IMS and ABI in achieving significant tort reform during the 1997 Iowa Legislature. Also discussed were the opinions of the business community on medical savings accounts, worker's compensation and what physicians charge for providing services to patients covered by ERISA plans.

The IMS strategic planning process continues with a series of five IMS Strategic Planning Task Force weekend meetings throughout the fall and winter. Details of those discussions will appear in future issues of *Iowa Medicine.*

Statewide outreach meetings set for 1998

Beginning in 1998, the IMS Board of Trustees plans to meet with groups of physician leaders around Iowa in conjunction with its monthly board meetings.

These "Physician Leader" meetings are part of an outreach effort to meet face-to-face with officers and administrators in large physician groups. IM

News from Iowa Medical Group Management Association (IMGMA)

Standardized credentialing form update

The IMGMA Insurance and Reimbursement Committee is announcing the acceptance of the standardized credentialing form. Officials from John Deere and Principal have notified IMGMA that they will accept the form. With this addition, all of the major plans in the state have agreed to accept the form. If anyone has had difficulty with acceptance of the credentialing form with any carrier, please notify a member of the Insurance and Reimbursement Committee or an IMGMA board member.

Committee members will be conducting an informal survey of IMGMA members who have purchased the software for the credentialing form to determine satisfaction with the software and address concerns or issues.

In response to many inquiries, Medicare and Medicaid will not accept the standardized form. Since these are government programs, they are required to use their own form. If you have a physician needing new members for Medicare, make certain you have them complete the newest Medicare form. There are three new Medicare forms and the old forms cannot be accepted.

(This article was written by Sue Hopkins, medical staff director, Mercy Clinics, Des Moines.)

IMS Update
continued

Focus on IMS Alliance

Stop America's Violence Everywhere (SAVE)

SAVE is a year-round project sponsored by the AMA Alliance. The program focuses on the problem of violence that exists everywhere—in homes, schools, streets and in the media. The cornerstone of the program is "SAVE Today"—one day each year dedicated to raising awareness of ways people can solve violence problems in their own communities. It is held on the second Wednesday of October.

On October 8, 1997, the IMS and IMSA will be commemorating "SAVE Today" with a press conference introducing our joint anti-violence initiative—"The Healing Path: A Guide For Surviving Domestic Violence." *The Healing Path* is a handbook which provides legal information, options and resources for victims of domestic violence. What began as a Polk County project, has now been adapted for use statewide. The handbook will be distributed to county medical societies, hospitals, shelters, police departments and county sheriffs.

(This article was written by Cindy Ehrecke, IMSA president.)

Specialty Society Update

Iowa Society of Anesthesiologists held its fall anesthesia update and business meeting on Saturday, October 4 at Mercy Medical Center, Cedar Rapids.

Iowa Society for Rehabilitation Medicine will hold its fall meeting on Friday, October 31 at IMS headquarters, West Des Moines.

Iowa Academy of Otolaryngology will hold its annual fall meeting in Iowa City on Friday, October 31 immediately following the Iowa Clinical Conference.

Iowa Vascular Surgery Society will hold its fall meeting November 1 in conjunction with the Surgery Post Graduate Conference in Iowa City, October 30-31.

Iowa Association of County Medical Examiners will hold its fall business and education meeting Friday, November 7 at the Des Moines Golf & Country Club, West Des Moines.

(For more information contact Sandy Nelson, manager, specialty society relations, 800/728-5398 or 515/223-2816.)



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Legislative Affairs

Managed care key issue for IMS

The IMS Committee on Legislation met for the first time in preparation for the 1998 state legislative session. Central to the committee's discussion were resolutions on managed care adopted by the 1997 IMS House of Delegates.

Those resolutions include:

- a call for Iowa licensure of clinical peers conducting utilization review
- proximate geographic access to appropriate specialties and other health care services in all areas of the state;
- mandatory grievance procedures for all managed care plans to resolve health benefit issues;
- provision of annual medical benefit expense ratios by all health benefit plans in an understandable format in enrollee materials and contracts;
- availability to all physieians of grading and weighting criteria used by managed care entities in their physician selection processes;
- protection of patient confidentiality and privacy consistent with recognized ethical standards.

Key to the committee's discussion was the recently-enacted Texas managed care legislation and the Iowa Principles of Agreement now in place between certain health care provider organizations including the IMS and certain managed care organizations. It was generally recognized by committee members that the Principles, embraced in initial form by a vote of the 1995 House of Delegates, are not binding upon the signatories. Question then centered on whether legislation similar to that in Texas is needed to protect the integrity of the physician-patient relationship and to discourage arbitrary processes and decisions of managed eare entities that impede patient choice and impair the delivery of quality health care.

The committee elected a two-pronged interim approaeh: (1) to engage in further fact-finding on problems encountered by physicians and their patients and (2) to seek formal commitments from all signatories to the procedural mechanisms of the Principles of Agreement, including implementation of an arbitration process to be used whenever a patient or physician is harmed by actions inconsistent with the Principles. The committee further directed an examination of statutory, regulatory and other avenues of redress that are available with respect to each of the House resolutions. The outcome of these efforts will be examined by the committee at its November 11 meeting.

(Note: The Committee on Legislation plans to send the Principles of Agreement to all IMS practicing physicians sometime in October.)

(continued)

News at a glance

By order issued August 25, Polk County District Court denied Iowa Psychological Association's (IPA) petition seeking relief from rules of the Department of Inspections and Appeals and the Hospital Licensing Board specifically recognizing only physicians as members of a hospital's medical staff. The IPA argued the rules were inconsistent with medical accreditation authorities and the laws of other states and were discriminatory against certified health providers in psychology. The court concluded the Hospital Licensing Board is empowered by the general assembly to define who should serve as members of a hospital medical staff. In upholding the Board's position, the court referenced testimony provided to the Board by the IMS Committee on Legislation supporting the rules. The IPA has 30 days to file an appeal to the Iowa Supreme Court.

SHARE YOUR MANAGED CARE STORIES WITH US

Physicians are asked to send the IMS written accounts of experiences they have had or that they know their patients have had with managed care organizations that had an impact on them, the physician-patient relationship or their patients' care.

The reports need not be lengthy and should not reveal patient names or other confidential patient information. Include physician name, address and telephone number (for follow-up testimonial purposes, if necessary); a short narrative description of the incident(s); the name of the managed care organization involved; processes, if any, utilized by the managed care organization to address the concern; and the final response of the managed care organization. This information will be held for internal purposes only.

Please submit all written accounts to the attention of Jeanine Freeman, vice president of public policy and advocacy at IMS.

Legislative Affairs
continued

Other legislative issues addressed

The IMS Committee on Legislation examined 1997 legislation and rules requiring physician reporting of all spontaneous terminations of pregnancy prior to 20 weeks gestation. IMS opposed this language as creating a heavy regulatory burden with little identified public health benefit. The committee voted to continue IMS opposition to this reporting requirement and to seek available remedies, including legislative relief, to eliminate it.

Other votes of the committee included: to continue efforts with the Iowa Board of Medical Examiners for regulatory clarification on current legal requirements for state licensure of physicians practicing medicine in Iowa via telemedicine; to work in concert with interested parties to develop effective programs for use of Iowa's share of the $24 billion appropriated under the federal children's health insurance initiative; to not support independent state licensure of orthopedic physician assistants; to support an amendment to current Iowa law requiring direct payment of expenses to county medical examiners by the county in which death occurs while also authorizing counties to seek reimbursement of such expenses from the deceased's county of residence; and to oppose mandatory Hepatitis B immunization of all school-age children.

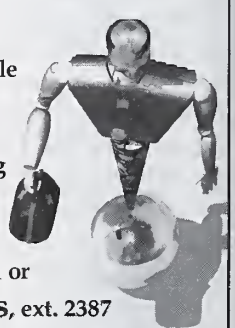
Use of interpreters in physicians' offices

The August 25 issue of *AMA News* addressed required use of interpreters to assist in the provision of medical care services to patients who are hearing impaired. AMA assistant general counsel, Mike Ile, explained that the Americans with Disabilities Act (ADA) prohibits public accommodations, such as physicians' offices, from discriminating against persons with disabilities. A patient disabled due to a hearing or visual impairment must be assisted through the use of auxiliary aids and services if necessary to ensure effective communication. Circumstances govern whether the type of assistance (i.e., interpreter, notes) was effective. Physicians should consult with their patients to determine what method of assistance will work.

Physicians are responsible for assuring compliance with the ADA and physicians must pay for the interpreter's services. Patients may not be billed for those services. Exception exists if payment would result in an undue burden upon the practice. The fact that the fees for an interpreter can exceed the cost of the medical service provided ordinarily would not rise to the level of an undue burden.

In a different twist on this matter, an HMO agreed in settlement with the New York attorney general to reimburse its physician providers for their costs in providing sign language interpreters to deaf patients. Patients had complained, stating that they could not get adequate medical care because the HMO refused to provide them with an interpreter. The HMO argued that it bore no legal responsibility for payment but the attorney general disagreed, claiming that state law requires HMOs to be in compliance with the ADA.

What about non-English speaking patients? Such patients may fall outside the jurisdictional reach of the ADA, but potential tort liability for failure to obtain informed consent may require the use of language interpreters or other assistive devices anyway. IM

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In conjunction with Foster Capital Management, Inc., the Iowa Medical Society is pleased to offer five one-day seminars for member physicians and their spouses interested in retirement and estate planning. Topics covered include:

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- **Planning for your heirs**—Basic elements involved in estate planning.
- **Getting your plan together**—How to get started.

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DATA & TECHNOLOGY

Disease management requires good information systems

Disease management systems (DMS) are becoming an important competitive strategy for providers in today's health care environment. Many providers view implementing DMS as a way to differentiate themselves in the market. Effective disease management systems rely heavily on state-of-the-art information system technology.

Disease management systems assist the physician in treating patients with like chronic conditions. Many systems prompt the physician to ask the patient certain questions or issue reminders if key lab results are out of normal ranges. This can be equated to clinical guidelines or best practices which attempt to reduce variations in treatment patterns.

Clinical benefits of DMS

Diabetes, asthma, hypertension, coronary artery disease, HIV/AIDS and high cholesterol are all chronic conditions that often can be managed through DMS. Research has shown that effective, intensive management of diseases can slow or even stop the complications associated with the condition.

One statistic behind the growth of DMS is that 1% of patients use about 33% of health care resources, and 5% of patients use 60% of resources. It makes sense, then, to implement strategies which will manage these patients in the most effective manner. That often means aggressively treating patients in an ambulatory setting so the illness does not progress to the point where a costly inpatient stay is required.

Key components to DMS

According to Francine Gaillour, MD, medical director for Phamis, Inc., there are six key components to DMS:

- Finding the patients with a particular chronic condition, then stratifying those patients to find the riskiest cases that would benefit most from DMS;
- Implementing care guidelines that prompt providers to take the right actions;
- Tracking care givers' adherence to the program;
- Monitoring patient compliance;
- Coordinating care among provider teams, and distributing patient-specific information wherever it's needed;
- Analyzing outcomes and fine-tuning guidelines.

Computers improve patient care

In this sense, DMS is doing more than just looking at outcomes. It guides the patient flow and the work flows of providers while distributing information to the patient about recommended care. Tracking patient compliance and maintaining timely communication with the patient is critical. This is where a comprehensive information system becomes necessary.

It is generally stated that 20% to 25% of health care costs are administrative. To maximize savings in health care delivery, organizations must use computers to improve patient care by controlling the other 75% of health care costs—the clinical component.

The ultimate goal is to put a friendly decision support information system in the hands of the physician and patient. This allows both to work together to manage diseases cost effectively. IM

It is generally stated that 20% to 25% of health care costs are administrative. To maximize savings in health care delivery, organizations must use computers to improve patient care by controlling the other 75% of health care costs—the clinical component.

For more information, call Ed Whitver, vice president of administration, 515/223-1401 or 800/747-3070.

Practice Management

News at a glance

The new documentation and coding guidelines for single organ system exams will change the way every physician documents the physical exam portion of the patient encounter. These guidelines will be effective January 1. See below for details on a comprehensive program offered to physicians and office staff to bring them

Important ICN programs offered

The IMS is sponsoring an Iowa Communications Network (ICN) program to bring physicians and office staff up to date on the latest guidelines for HCFA documentation and coding single organ system exams.

Criteria for the affected exams is organized into three modules and each module is offered three times. The program is being taught by Barb Pierce of the IMS practice management staff. An informational brochure including a registration form was mailed to all IMS members and clinic managers in September.

The first seminar was held September 29 via the ICN in 16 cities across Iowa. Seminars continue throughout October as advertised in the brochure. The November ICN sites have been confirmed as follows:

Module A: Multisystem ENT, GU female and male; November 11—Ankeny, DMACC, Bldg. 6, Room 18; Anita HS; Bettendorf/Scott CC1, Room 210; Cedar Rapids, Mount Mercy, Room 050; Clear Lake AEA, State Room; Clinton, GATCI, Room 16; Council Bluffs AEA, ICN Room; Des Moines Roosevelt HS, Room 106; Dubuque NG, ICN Room; Fort Dodge IACCC, Room 206; Iowa City HS, Room I002; Marshalltown AEA, ICN Room; Muscatine HS, Room 135; Ottumwa AEA, ICN Room; Sioux City North HS; Storm Lake, Buena Vista1; Waterloo AASF, Room 6.

Module B: Multisystem, eyes, psychiatric, skin, hematologic/lymphatic/immunologic; November 18—Ankeny, DMACC, Bldg. 6, Room 18; Anita HS; Bettendorf/Scott CC1, Room 210; Cedar Rapids, Mount Mercy; Clear Lake AEA, State Room; Clinton, GATCI, Room 16; Council Bluffs AEA; Des Moines Roosevelt HS, Room 106; Dubuque NG, ICN Room; Fort Dodge HS, Room 12; Iowa City HS, Room I002; Marshalltown AEA; Muscatine HS, Room 135; Ottumwa AEA; Sioux City North HS; Storm Lake, Buena Vista1; Waterloo AASF, Room 6.

Module C: Multisystem, neurological, musculoskeletal, cardiovascular, respiratory; November 20—Ankeny HS, Room 522; Anita HS; Bettendorf AEA; Cedar Rapids, Mount Mercy, Room 050; Clinton, GATCI, Room 16; Council Bluffs AEA, ICN Room; Des Moines Roosevelt HS, Room 106; Dubuque NG, ICN Room; Fort Dodge HS, Room 12; Iowa City HS, Room I002; Marshalltown AEA; Mason City, NIACC, Room 106; Mount Joy AASF; Ottumwa HS, Room 155; Sioux City North HS; Storm Lake, Buena Vista1; Waterloo AASF, Room 6.

Correction: The October 15 program at the Atlantic site will be held in the middle school, Room 109, rather than the high school. IM

Key for abbreviations to sites:
AASF—Army Air Aviation Support Facility
AEA—Area Education Agency
AG—Air Guard
CC—Community College
GATCI—Graphic Arts Technology Community Institute
HS—High School
NG—National Guard

Practice Management Workshops for You

Retirement Planning for Physicians & Spouses

November 6, IMS headquarters, West Des Moines
November 18, IMS headquarters, West Des Moines

Retirement and estate planning are relevant topics for everyone at all career stages. This is an opportunity for both individuals and couples to take advantage of their earning years. Instructor: Jerry Foster, Foster Capital Management, Inc.

Health Insurance Overview

November 12, West Des Moines

Overview of basic health insurance. Instructor: Cynthia Swanson, Seim, Johnson, Sestak & Quist.

ICD•9•CM Coding

November 18, Davenport

This seminar offers something for every level of coder. Instructor: Mary Pat Wohlford-Wessels, University of Osteopathic Medicine and Health Sciences.

For more information or to register for any IMS practice management workshop, call Sherry Johnson at IMS Services, 515/223-2816 or 800/728-5398.

Midwest Medical Insurance Company Focus on Risk Management

Drug-seeking patients: avoid getting caught in their trap

A patient calls after hours requesting pain medication. She claims she is a patient of your partner's and is recovering from surgery. Her regular pharmacy is closed and she desperately needs a refill on her Percodan. You authorize the refill but find out the next day that she is not your partner's patient and that no one in the clinic has ever heard of her.

This type of scenario and others confront physicians every day as drug-seeking patients develop innovative ways of obtaining narcotics by prescription. Clearly some patients are truly in need of narcotics refills and legitimately deserve immediate attention.

To exercise caution, prevent patient injury and reduce your liability exposure:

- Establish a clinic policy on how routine narcotic refills are to be handled, an after-hours policy on narcotics refills and a requirement establishing how often the patient must be seen before renewing narcotic prescriptions.
- Write initial prescriptions for narcotics only after examining the patient.
- Handle off-hours requests for narcotics by prescribing a limited quantity (i.e., enough to carry the patient through the night) or referring the patient to the emergency department for evaluation.
- Document all prescriptions and refills on a centralized medication record. Check this record before authorizing any prescriptions or refills to prevent overprescribing.
- Avoid using digits for medication quantities. "Ten" cannot be alter to "one hundred" the way "10" can. Similarly use "none" for refills rather than "0" which can be turned into "10."
- Document when established patients make inappropriate refill requests by indicating the refill was denied. If you see a number of such entries, patient counseling may be indicated.
- Keep medications and prescription pads locked up in the clinic. If a patient steals drugs or prescription pads, that may be a crime reportable to the local law enforcement. If a criminal report is made, report only the facts of the crime and nothing about the patient's medical condition.

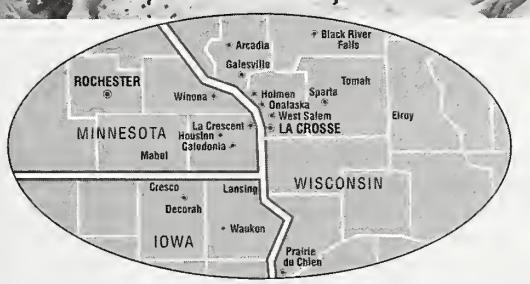
For more information contact Lori Atkinson, MMIC risk management supervisor, Midwest Medical Insurance Company, West Des Moines Office, PO Box 65790, West Des Moines, Iowa 50265; 800/798-9870 or 515/223-1482.



Franciscan Skemp Healthcare has a 112-year commitment to providing patient-focused and family-centered care. Now affiliated with Mayo, we continue to provide quality medicine combined with streamlined access to renowned, complex specialty care. We are an integrated delivery network serving a population base of 350,000 and including three hospitals and 12 clinics with 170 active medical providers.

Opportunities are available in: Family Practice Residency Faculty; Emergency Medicine; Hematology/Oncology; ENT; Orthopedics/Sports Medicine; Occupational Medicine; Radiology; Urology; Neonatology; Gastroenterology; and Psychiatry. The practices are available in an ideal, family-oriented environment with outstanding recreational and cultural activities. Excellent public and private schools.

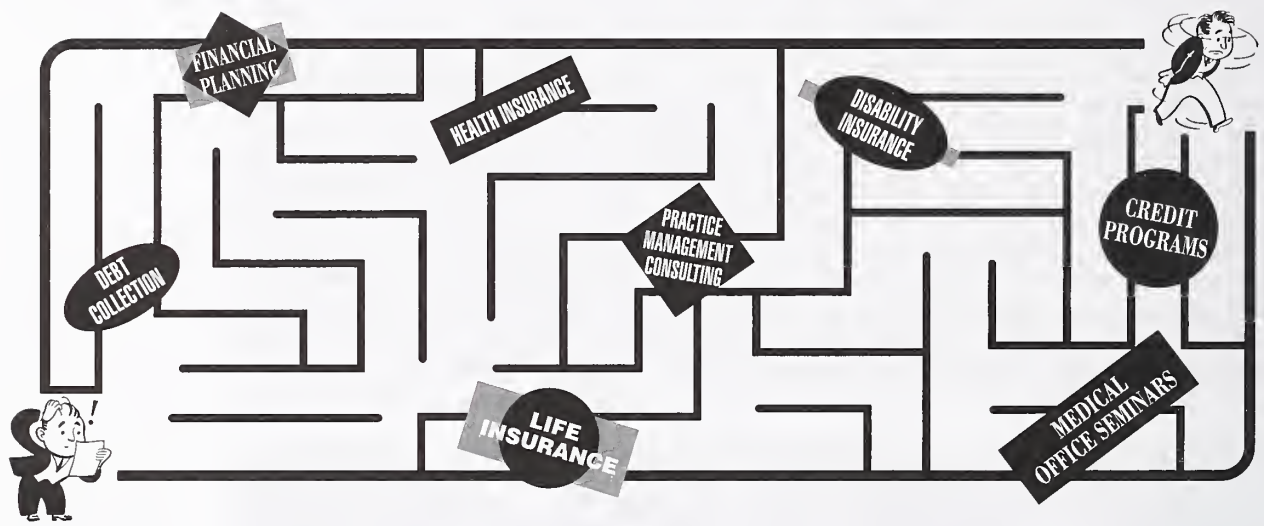
Call Tim Skinner (tskinner@fsh.mayo.edu) or Bonnie Guenther (bguenthe@fsh.mayo.edu) at 800/269-1986. Or visit our website at www.mayo.edu/fsh. ***Not a health manpower shortage area.***



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It's A Mazing The Decisions Involved In Running A Medical Practice



You're a physician and you know the complexities of running your own practice. There are many services you and your staff need to operate more efficiently. Weaving your way through all of the programs and products, however, can be overwhelming.

Sure, you could have a piecemeal approach to your needs. But why, when you could have one-stop shopping with IMS Services. With many of the services available in one location, it can make your practice operate smoother and keep you on the road to running a successful practice.

So contact IMS Services to be unmazed with all the programs and products available. For further information on any of the following, please call **515/223-2816 or 800/728-5398.**

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- **Debt Collection**
- **Electronic Medical Records Endorsement**
- **Individual Travel Club**

IMS SERVICES

A SUBSIDIARY OF THE IOWA MEDICAL SOCIETY
1001 Grand Avenue, West Des Moines, Iowa 50265

Newsmakers

Awards, appointments, etc.

Dr. John Barnes, Missouri Valley, was honored by the Iowa Academy of Family Physicians as the 1997 Iowa Family Doctor of the Year. The presentation was made during the IAFP's Annual Meeting and Scientific Assembly in August in Des Moines. Dr. Barnes will become Iowa's nominee to the American Academy of Family Physicians for the 1998 National Family Doctor of the Year. Two other family physicians were also recognized at the meeting: **Dr. Charles Driscoll**, West Branch, and **Dr. Eric Evans**, Cedar Rapids. Dr. Driscoll received the President's Award for his long leadership history with the IAFP and Dr. Evans was named the 1997 Iowa Medical Educator of the Year. Dr. Evans was nominated by students and colleagues at the UI College of Medicine, Department of Family Practice. **Dr. Lynette Iles**, Washington family practitioner, volunteered her medical services to flood-ravaged Grand Forks, North Dakota. **Dr. John Stokes**, professor of medicine at the UI College of Medicine and VA Medical Center physician, has been named secretary-treasurer of the American Society of Nephrology. IM

News at a glance

*The following physicians were newly-elected as officers of the Iowa Academy of Family Physicians: **Dr. John Carroll**, Carroll, president; **Dr. George Kappos**, Ankeny, president-elect; **Dr. Steven Wolfe**, Spencer, vice president; **Dr. Ron Hiemstra**, Cedar Falls, secretary-treasurer. **Dr. Richard Jongewaard**, Sioux Center; **Dr. Gerard Stanley**, Onawa; and **Dr. Glen Hanson**, Greenfield were also elected to the board of directors. **Dr. Laine Dvorak**, Humboldt was elected as a delegate to the American Academy of Family Physicians and **Dr. A. Clinton MacKinney**, Cresco was elected as an alternate delegate.*



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"After the sale, it's the SERVICE that counts"

Practicing pure medicine in Iowa

Free clinics

The simplicity and joy of practicing medicine in free clinics has been discovered by numerous Iowa physicians. They tell of the need to practice pure medicine for Iowans who truly need free medical care. They also share how to start a free clinic, step by step. It's simple, they say, with a little help from colleagues and the community.



Dr. Mike O'Brien examines Amber Beaman's ears during a preschool physical at the Mae E. Davis Free Medical Clinic at Prayer of Faith Church of God in West Des Moines.

What convinced Dr. James Blessman to give up his family practice and donate more of his time to caring for uninsured patients?

There's a one-word answer . . . idealism.

"Working in a free clinic brings back the joy of practicing medicine," James Blessman, MD says. "It's so different working in a free clinic. It feels better. People are appreciative."

Two years ago, Dr. Blessman quit his family practice at Mercy Iowa Occupational Clinic in Des Moines to donate his time to free clinics.

MELANIE FINKE
Ms. Finke is coordinator of marketing communications with the Iowa Medical Society.

And it's this need to practice pure medicine that keeps free clinics open for Iowans in need of free medical care.

A free clinic network

Dr. Blessman opened his first free clinic in 1991 to serve the people of his community at Polk City United Methodist Church.

With the help of the church's minister Rev. Larry Conrad, Dr. Blessman transformed the church secretary's office into an exam room using donated medical equipment and prescription samples.

It wasn't difficult to start the clinic, according to Dr. Blessman. "Money is not a problem," he says. "If you take the time to ask for the money, you'll get it." The difficulty lies in having the support of physicians in the community. "The project needs to come from the doctors for it to be successful," he emphasizes.

Dr. Blessman's Polk City clinic has grown into the Health Care Access Network (HCAN) encompassing nine clinics. The clinics are located in Des Moines, Waterloo, Marshalltown, Oskaloosa and Perry. These clinics see about 10,000 patients a year. The network is supported in part by grants from Wellmark BlueCross BlueShield of Iowa Foundation and the Robert Wood Johnson Foundation.

Keep it simple

Dr. Blessman says the key to starting a free clinic is keeping it simple.

Most of the HCAN clinics have simple room setups, with cubicles serving as exam rooms and rows of chairs serving as waiting rooms.

Patients are sometimes registered by the time the clinic officially opens. Registration forms are provided in English and Spanish. A receptionist directs the flow of patients.

HCAN clinics provide only primary care. Many clinics have negotiated with their local hospitals to receive lab tests at cost for clinic patients who need more extensive care. Since most tests cost less than $10, patients are asked to pay for the tests if possible. In Marshalltown, patients are treated by local emergency room personnel but do not get placed in the computer for billing.

All equipment is donated or purchased with money received from grants. Physicians generally bring their own stethoscopes.

Vaccinations are provided by the Iowa Department of Public Health, and prescription samples are donated by physician offices. Volunteer nurses work in the clinics to ensure that vaccination records are accurate.

Most of the HCAN clinics are held in churches, providing an economical location for the clinic. Churches charge HCAN only $1 for rent per year. Startup clinics may also receive tax-exempt status if they are created under a church's business structure.

Simplicity in action

A visit to the Mae E. Davis Free Medical Clinic in West Des Moines shows the simplicity of the operation.

Nursing students from Grand View College in Des Moines, overseen by their professor Ellen Strachota, PhD, sweep waiting patients to one of three stations for preliminary screenings. They review medical histories, check patient blood pressures and record patient complaints. They also take blood and urine samples.

Once in the exam cubicles, patients are examined by the physician on duty who is often assisted by medical students.

This gives patients the opportunity to talk about their complaints with a physician or physician-in-training.

Mike O'Brien, MD, a Des Moines gastroenterologist, surveys a chart before heading into the next exam cubicle.



Third year medical student Andrea Silvers tests Jade Shamble's reflexes at the Mae E. Davis Free Medical Clinic. Silvers is completing rotations at Iowa Health System.

"I'm not used to working with children and general practice patients," he says with a self-deprecating grin. "Sometimes I think I learn more from the medical students."

Finishing the exam, Dr. O'Brien confers with University of Iowa medical student Andrea Silvers about the best prescription to give the child and sits down to fill out the limited paperwork required by the free clinic.

Jeff Dumermuth, one of the clinic's site coordinators, receives the paperwork and inputs the simple record into the clinic's computer. All medical records are kept at the church.

The health care crew saw over 30 patients in the three hours the clinic was open.

Five key steps to starting a free clinic

If you are interested in starting a free clinic, Dr. Blessman suggests volunteering in an established clinic. Get to know how the clinic runs and what supplies you will need. He offers the HCAN clinics as a good training ground.

The second step is to meet with fellow physicians to gain support. "Don't start a clinic before having adequate help and physician backup," Dr. Blessman says.

5 steps to start a free clinic:

1. Volunteer at an established clinic
2. Gain support from colleagues
3. Recruit nurses as site coordinators
4. Determine the logistics, such as location, supplies and liability
5. Get the word out

For copies of forms and contracts to use when setting up free clinics, contact Bev Corron, 515/223-1401, at the Iowa Medical Society.

For more information about setting up free clinics, contact Paula Cramer, 515/965-6810, at the Health Care Access Network.

HCAN recommends operating with five or six physicians. This ensures that no one gets burned out by having to work a number of weeks in a row. One physician is selected to be the clinic's medical director, responsible for working with other clinic personnel to make sure the clinic runs smoothly.

Drumming up support among the physician community can guarantee the success of your clinic. Even if physicians do not volunteer their time to the clinic, they may refer patients who need free medical care or remember the clinic the next time they have a bucket of sample prescriptions.

The next step is recruiting nurses to act as site coordinators. Site coordinators are responsible for scheduling personnel to work the clinics each week. They also oversee the clinic's records and supplies to make sure the clinic is stocked and ready to run each week.

The fourth step is determining the logistics of the clinic. Begin to collect equipment and supplies. Decide where the clinic will be located, and draw up an agreement with the location concerning liability. HCAN has standard contracts they use for each clinic.

You will also have to address the liability issue. Volunteer physicians need to confirm that their liability insurance covers work off their practices' premises. If it does not, the state offers protection for professionals volunteering in free clinics.

> **"Working in a free clinic brings back the joy of practicing medicine. It's so different working in a free clinic. It feels better. People are appreciative."**
> **Dr. James Blessman**

The clinic must register with the state as a qualified program before providers will be approved for this coverage. Contact Carol Barnhill at the Iowa Department of Public Health, 515/281-6211, for more information concerning this program and to obtain applications.

"People are most fearful about legal issues and money when setting up free clinics," Dr. Blessman says. Contracts can generally clear up legal concerns. HCAN has standard contracts and forms available for physicians interested in starting up free clinics. The contracts were created with pro bono legal help.

Dr. Blessman estimates that it costs about $1,700 for the initial clinic setup. Running the clinics costs only about $800–1,000 a year. These costs can be attributed to supplies which are not typically donated.

The final step in creating a successful clinic is to publicize the hours of the clinic. Dr. Blessman has found that word-of-mouth is the best means for publicizing free clinics.

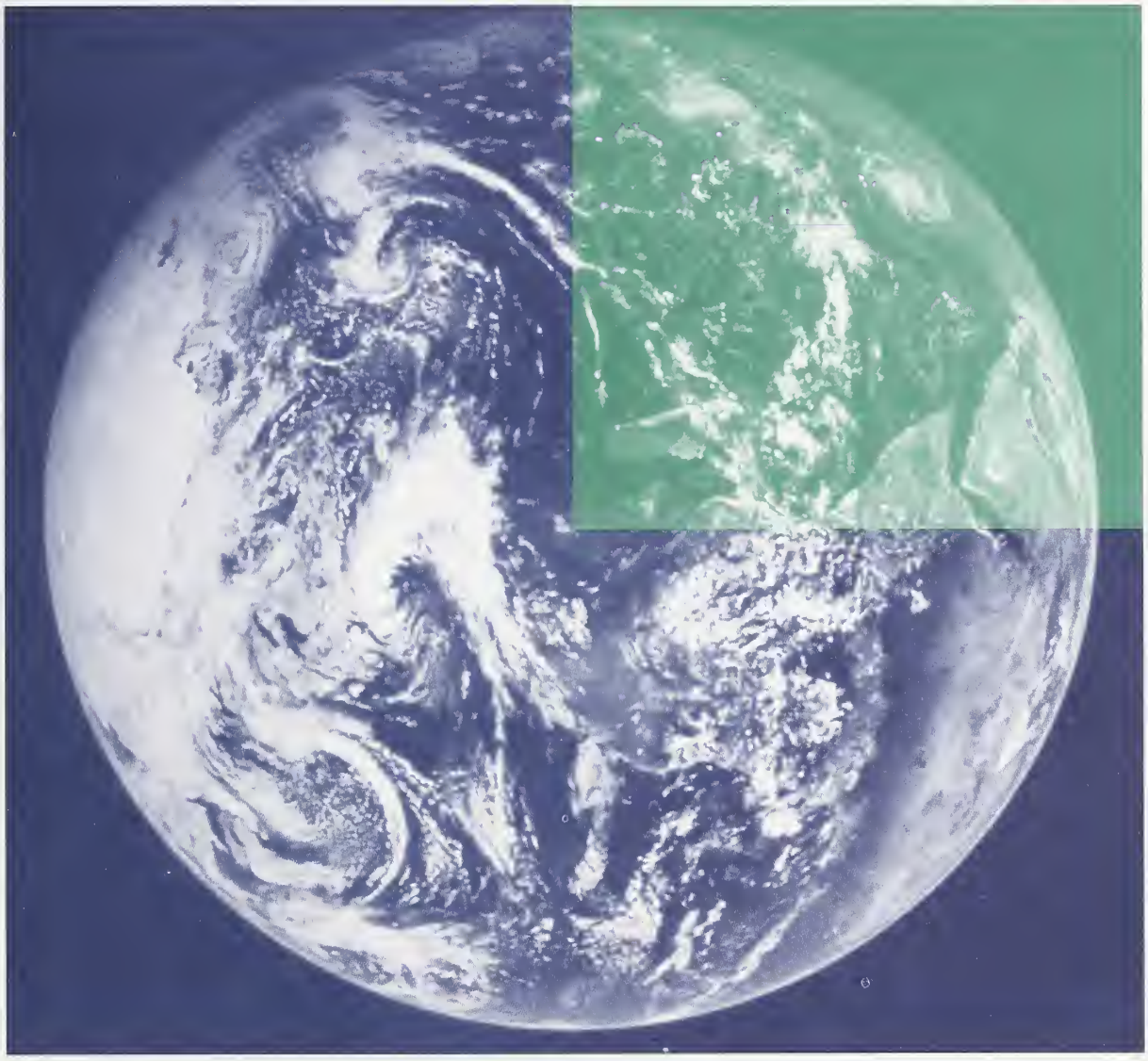
Post flyers at hospitals or contact physicians and their offices directly to make them aware of the clinic. Talk to school nurses and ministers, so they might refer patients to the free clinic.

You might also consider talking to your local newspaper editor about running an article about your free clinic in the community or health pages of the newspaper. IM



Ellen Strachota, PhD, professor of nursing at Grand View College in Des Moines, helps senior nursing student Jayne Douglas administer a polio vaccine. Vaccinations at the free clinics are provided through the Iowa Department of Public Health.

Moving Toward the New Millennium

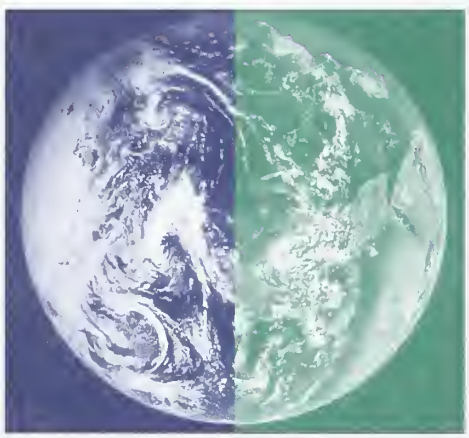


1997 Iowa Health Care Information Expo

Thursday, November 13, 1997

Embassy Suites Hotel, Des Moines

Moving Toward the New Millennium



Technology does all sorts of things for us: from the routine—accessing cash day or night, to the mystifying—probing the surface of planets, to the extraordinary—communicating with people all over the world instantaneously.

In the field of health care, technology helps providers submit claims electronically; allows physicians in various parts of the country to discuss treatment methods face-to-face; and enables providers to capture, analyze, and report data.

But technology is only as useful as we make it. Here's your chance to "see the big picture" as it relates to technology in health care. At the 1997 Iowa Health Care Information Expo, you'll have an opportunity to walk away with the "hows" and "whys" on topics from fiber optics, to the Internet, to integrating multiple data sets.

This conference is jointly sponsored by the Association of Iowa Hospitals and Health Systems, Iowa Methodist Medical Center, and the Iowa Medical Society—organizations that realize the vital role technology plays in treating patients, increasing access to health services, and improving the accuracy of data collection and use.

1997 Iowa Health Care Information Expo
Moving Toward the New Millennium

Thursday, November 13, 1997

7:30 a.m. **Registration and Vendor Exhibits**

9:00 a.m. **Welcome**

9:15 a.m. **Information Technology in Health Care in the Next Millennium**
Dr. Bauer will establish a context for the entire conference by exploring the remarkable implications of concurrent revolutions in health care delivery and information technology. He will forecast the organization of our health care delivery system in the early 21st century–with special focus on new clinical paradigms that will almost certainly result from the unprecedented potential for synergy between medical science, computers, telecommunications, and patient expectations.



Jeffrey Bauer, Ph.D.
President,
The Bauer Group
Hillrose, CO

10:15 a.m. **Break**

10:30 a.m. **Break-Out Session #1**

Health System Information Network Initiatives *Bob Boysen*
Vice President Information
Iowa Health System
Des Moines, IA

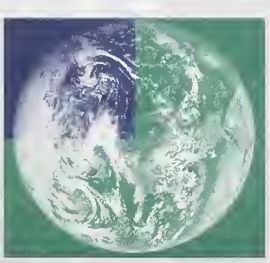
Pat Heinemann
Project Manager
Mercy Health Services
West Des Moines, IA

Managed Care Data Reporting Directions *Jeffrey Bauer, Ph.D.*
President, The Bauer Group
Hillrose, CO

Rural Community Fiber Optic Communications Projects *Stephen L. Goeser*
CEO, Shelby County Health System
Harlan, IA

Martin Guthmiller
Administrator/CEO
Orange City Hospital and Clinic
Orange City, IA

Greg Miner
Administrator, Loring Hospital
Sac City, IA



Computer Network Decision-Making: Exploring Options *Phil Stravers*
Iowa Computer Enterprises
Pella, IA

Moving Toward

11:30 a.m. **Vendor Exhibits**

12:00 p.m. **Box Lunches**

1:00 p.m. **New Tools in Information Technology:**
Moving From Memory-Based to Expert-Based Systems
Dr. Weed will offer attendees a new set of tools to initiate change in health care philosophy and methodologies. These tools act as electronic extensions to the human mind, aiding in accessing, comprehending, and coupling pertinent information from an overwhelming body of knowledge to the needs of unique individuals.



Lawrence Weed, M.
President,
PKC Corporation
Burlington, VT

2:00 p.m. **Break**

2:15 p.m. **Break-Out Session #2**

Assessing Patient Perceptions:
Turning Information into Action

John Sena, Ph.D.
Assistant to CEO
Healthcare Research Systems, Ltd.
Columbus, OH

Problem Knowledge Couplers: Examining the Tool

Lawrence Weed, M.D.
President, PKC Corporation
Burlington, VT

Telemedicine in Iowa

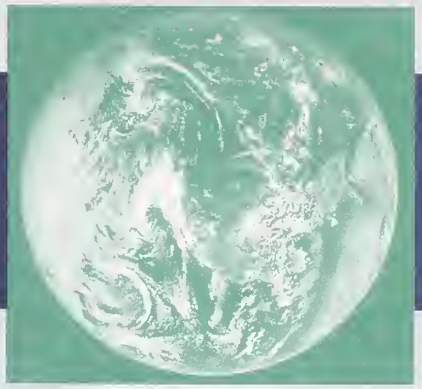
Paul Maakestad
Project Director, Midwest Rural Telmedicine Consortium
Des Moines, IA

Directions in Electronic Data Interchange

Lem Stewart
President, EDI Division
QuadraMed
Larkspur, CA

3:15 p.m. **Break**

New Millennium



3:30 p.m. **Break-Out Session #3**

Distance Learning & Information Exchange
in Relation to Telemedicine

Michael Kienzle, M.D.
Associate Dean for Clinical Affairs and Medical Communications
Director, National Laboratory for the Study of Rural Telemedicine
University of Iowa Hospitals & Clinics
Iowa City, IA

Electronic Patient Records:
Opportunities and Barriers

Linda Moline, R.R.A.
Vice President, Professional Services
Dynamic Healthcare Technologies
Maitland, FL

Health Care Resources on the Internet

Cathy Perley
Media Service Manager, St. Luke's Health System, Inc.
Sioux City, IA

Melanie Finke
Marketing Communications Coordinator
Iowa Medical Society
West Des Moines, IA

Health Care Information: Integrating Multiple Data Sets

Robert Reiter, M.D.
Associate Professor
University of Iowa College of Medicine
Director, Clinical Outcomes & Resource Management
University of Iowa Hospitals and Clinics
Iowa City, Iowa

4:30 p.m. **Adjourn**

Learning Objectives:

At the conclusion of this educational session, the participants should be able to:

- Develop an understanding of key trends in clinical sciences and information technology
- Apply trend analysis to forecasting likely changes in the medical care delivery system
- Identify important changes in the collection and analysis of health care information
- Apply lessons from other industries, both preventively and proactively
- Relate changes in managed care to evolving needs for new types of data and new applications of information
- Apply an understanding of managed care's evolution to data needs in specific health care organizations
- Discuss the benefits of electronic medical records and be aware of their current uses and limitations
- Increase their awareness of health care resources accessible on the Internet

Location and Accommodations
The Embassy Suites Hotel, 101 East Locust Street, Des Moines, IA, will host this seminar. To make reservations, contact the hotel directly at (515) 244-1700, and mention you are attending this IH&HS meeting to take advantage of the special rates of $92 single or $102 double occupancy. The special rate expires October 27, 1997.

To reach the Embassy Suites via I-235 from either direction, take the East 6th Street exit, proceed south on East 6th until you reach Grand Avenue. Turn right onto Grand and proceed until you reach East 1st Street. Turn left onto East 1st and the Embassy Suites will be one block south. Parking is available in the hotel's parking lot across the street for $3 a day or there is limited on-street metered parking. If you need additional directions or a copy of a map, please call Linda Parker at IH&HS.

Seminar Fee
The seminar fee, if received prior to October 30, is $99 each or $79 each for two or more participants who are members of or employees of IH&HS organizations or IMS. The seminar fee of $109 each participant or $89 each for two or more will be charged for registrations received after October 30, 1997. Registrants who are not employees of IH&HS organizations or IMS members will be charged $158. The registration fee for this program includes tuition, materials, luncheon and all break refreshments. Please make check payable to the Association of Iowa Hospitals & Health Systems (IH&HS).

Continuing Education Credits
This program is jointly sponsored by Iowa Methodist Medical Center. Iowa Methodist Medical Center is accredited by the Iowa Medical Society to sponsor continuing medical education for physicians. Iowa Methodist Medical Center designates this continuing medical education activity for 3 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

.6 Nursing CEUs will be awarded by IH&HS Iowa Board of Nursing Provider #4. To receive CEUs or a certificate of attendance, full attendance at every session is required. No partial credit will be granted.

IH&HS is authorized to award five hours of pre-approved Category II (non-ACHE) continuing education credit for this program toward advancement or recertification in the American College of Healthcare Executives. Participants in this program wishing to have the continuing education hours applied toward Category II credit should list their attendance when making application to the American College of Healthcare Executives for advancement or recertification.

Registration Instructions
Complete and return the registration form by October 30, 1997, to Linda Parker, program registrar, IH&HS, 100 E. Grand Avenue, Des Moines, IA 50309. If the check is not ready by the October 30 deadline, you may fax your registration to IH&HS at (515) 283-9366 and mail the original registration form with a check to the address above. Please indicate on your registration form that you have previously faxed it. You may also register through the events section of the IMS web site at www.iowamedicalsociety.org.

Cancellation/Refund Policy
The sponsors reserve the right to cancel the program for insufficient registration. In case of sponsor cancellation, preregistered participants will be notified and full refunds provided. PLEASE NOTE: Requests for cancellations/refunds must be received by November 6, 1997. A 15% processing fee will be charged for all cancellations. Cancellations must be called into Linda Parker at 515-288-1955. If you cancel, please make certain you receive a written confirmation of your cancellation from IH&HS. If you have not received a written confirmation within 72 hours, call Linda Parker at IH&HS. After November 6, 1997, registrants are no longer eligible for refunds. Substitutions may be made at any time.

Neither IH&HS nor IMS discriminate in educational programs on the basis of race, religion, color, sex or handicap. IH&HS and IMS wish to ensure no individual with a disability is excluded, denied services or segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids and services. If you need any of the auxiliary aids or services identified in the Americans with Disabilities Act in order to attend this program, please call (515) 288-1955, fax (515) 283-9366.

University of Maryland
Baltimore

1997 Iowa Health Care Information Expo
Moving Toward a New Millennium
November 13, 1997
Embassy Suites Hotel, Des Moines, IA

[PLEASE PRINT OR TYPE THE INFORMATION BELOW]

First Name _____ Last Name _____

Nickname _____ Title _____

ACHE Credentials _____

Organization _____

Organization Mailing Address _____

City/State/Zip Code _____

Area Code & Telephone Number (_____) _____

For continuing education purposes, please provide the following:

Iowa license number _____

Social Security number _____

BREAK-OUT SESSIONS
Please ✓which break-out sessions you plan to attend. Each break-out session has limited seating. Sessions will be assigned on a first-come, first-served basis.

BREAK-OUT SESSION #1 - 10:30 a.m.
❑ Health System Information Network Initiatives
❑ Managed Care Data Reporting Directions
❑ Rural Community Fiber Optic Communications Projects
❑ Computer Network Decision-Making: Exploring Options

BREAK-OUT SESSION #2 - 2:15 p.m.
❑ Assessing Patient Perceptions: Turning Information into Action
❑ Problem Knowledge Couplers: Examining the Tool
❑ Telemedicine in Iowa
❑ Future Directions in Electronic Data Interchange

BREAK-OUT SESSION #3 - 3:30 p.m.
❑ Distance Learning & Information Exchange in Relation to Telemedicine
❑ Health Care Resources on the Internet
❑ Electronic Patient Records: Opportunities & Barriers
❑ Health Care Information: Integrating Multiple Data Sets

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ON THE LEGAL FRONT



JEANINE FREEMAN, JD

Professional literature recognizes a distinction between intervention for an incompetent or unethical practitioner and a physician who is impaired. Empathy, coupled by a desire to assist, is a dominant response by colleagues who observe the struggles of an impaired physician. At the same time, legitimate concern for patient safety and the long-term health and professional competence of the impaired physician often require intervention. Reporting is a key step in the intervention process.

AMA Ethical Opinion 9.031 places an affirmative obligation on physicians to report an impaired colleague. Where the efforts of a hospital's impaired physicians' committee or a medical society's physician health program prove ineffective, or where an imminent threat to patient safety exists, a report should be made to the state licensing board.

Two reporting avenues exist through the Iowa Board of Medical Examiners (BME). The first requires a physician to report firsthand knowledge of a colleague's inability to practice reasonably and safely due to an impairment (see last month's column, p. 281). The second is self-reporting to the Impaired Physicians Review Committee (IPRC), a BME committee that works independently of the BME. The proceedings of the IPRC, including self-reports made to it, are confidential and not subject to public release.

A physician who knows an impaired colleague has self-reported to the IPRC is not required to file a report with the BME.

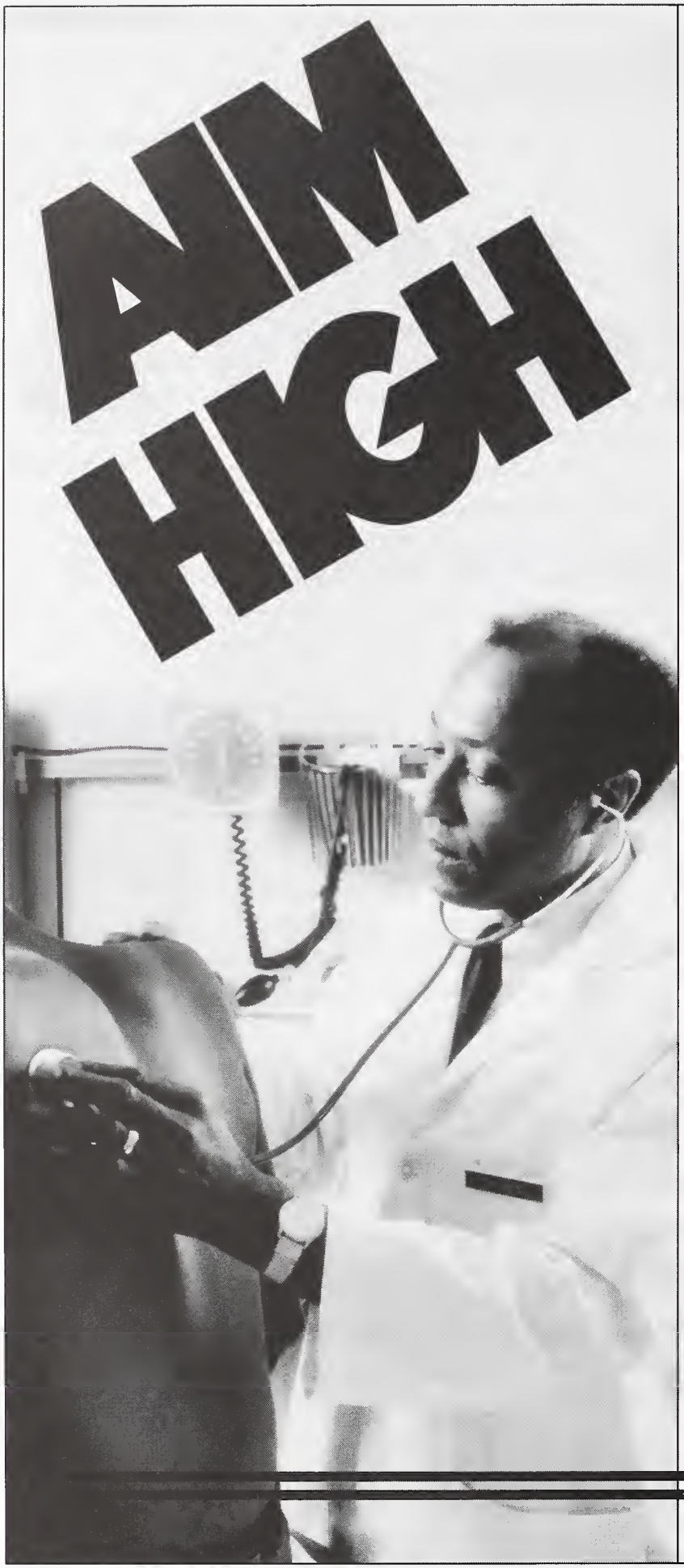
The IPRC is available only to eligible physicians who self-report. Physicians already under investigation by or under the disciplinary jurisdiction of the BME for competency matters are not eligible to participate in the IPRC program. A physician who knows an impaired colleague has self-reported to the IPRC is not required to file a report with the BME.

A report by a physician regarding an impaired colleague, whether to the BME or to the IPRC, invokes the disciplinary jurisdiction of the BME and renders a subsequent self-report untimely; as a matter of practice, though, some time (usually 24 hours) has been given to allow the impaired colleague to self-report to the IPRC. A self-report is too late if filed after a hospital's report to the BME of final action taken against an impaired physician's privileges. Hospitals are required by law to file such reports with the BME within 10 days of final action by the hospital trustees.

An individually-tailored contract for evaluation, treatment and monitoring governs the relationship between an impaired physician and the IPRC. The BME intervenes only upon receipt of a report from the IPRC that the impaired physician failed to adhere to contract terms. The BME also pursues complaints by any person on other disciplinary matters even though the physician is under contract with the IPRC. IM

The information in this column is not intended to be legal advice. If you have specific questions or concerns, contact your attorney.

Ms. Freeman is vice president of public policy and advocacy at the Iowa Medical Society.



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AIR FORCE

Statewide trauma care system update

GUEST EDITORIAL



TIMOTHY PETERSON, MD

An act relating to the development and implementation of a coordinated statewide trauma system (SF118) was signed into law on April 19, 1995. This was the result of over three years of study by the Iowa Trauma System Development Consortium, formed by the Iowa Department of Public Health (IDPH) and funded by the Federal Trauma System Development Act of 1991.

The goal of a trauma care delivery system is to match the injured patient's needs to resources so optimal and cost-effective care is achieved. Trauma care represents a continuum that is best provided by an integrated system involving prevention, acute care and rehabilitation. This requires cooperation of trauma care providers and resources throughout the state along each phase of trauma care. A systems approach recognizes this continuum of care and has been shown to reduce overall costs, disability and death associated with traumatic injury.

A systems approach recognizes this continuum of care and has been shown to reduce overall costs, disability and death.

The Iowa trauma plan and statewide trauma care system legislation have been geared to achieve these goals in recognition of the unique needs of our predominantly rural population. To assure all persons have access to an organized delivery system for trauma care, Iowa's trauma care system is designed to be an 'inclusive' system involving all out-of-hospital and hospital providers. All sectors of the emergency medical service system are to be involved with system development and implementation to the extent that they will participate at their self-defined level of care commitment.

The IDPH was designated as the lead agency responsible for development and implementation. A Trauma Systems Advisory Council (TSAC) and System Evaluation Quality Improvement Committee (SEQIC) were also established by SF118. The TSAC made recommendations to the department for adoption of administrative rules. The rules were adopted by the Board of Health in January of 1997 with a four-year implementation or grace period for compliance.

The SEQIC developed a process management flow model for evaluation and is formulating indicators/audit filters for the out-of-hospital and hospital components of trauma care. The assurance of data confidentiality has been built into SF118 and the related administrative rules.

Any system is only as strong as its weakest link. The challenge for physicians is to work with their local hospitals and ambulance services to better organize trauma care within their local EMS system. Success can only be achieved when a joint commitment exists which involves the hospital board of directors and physician medical staff. IM

For more information on the statewide trauma care system contact trauma coordinator Mary Jones with the Bureau of EMS at 515/281-3732.

Dr. Peterson is medical director of the Bureau of Emergency Medical Services at the Iowa Department of Public Health, Des Moines.

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Staff Neurologist
Department of Neurology and Psychiatry
Mercy Hospital Medical Center
Des Moines, Iowa

Raymond Moore, Ph.D.**Psychology**
Psychologist in Private Practice
Des Moines, Iowa

Rick Turner, M.D.**Psychiatry**
Mercy Psychiatric Consultant/Liaison Services
Mercy Franklin Center
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Reverend Larry Conrad**Theology**
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The Journal
of the Iowa Medical Society

Surgical treatment of Parkinson's disease

● *Patrick Hitchon, MD; Kenneth Follet, MD; Pamela Schneider; Robert Rodnitzky, MD; Todd Ajax, MD; Judy Dobson; James Torner, PhD*

Parkinson's disease (PD) most commonly afflicts the elderly of both sexes and occurs in approximately 0.5% of the population. The main cause of PD is reduction in the available levels of dopamine in the substantia nigra, the putamen and striatum.[4] In idiopathic cases, the cause of degeneration in the substantia nigra with the secondary decrease of dopamine is unknown.

Contributing factors to Parkinson's disease

There are, however, many contributing factors to this degenerative process including viral infections, vascular disease, trauma and drug toxicity. This reduction in dopamine results in an impairment in the control of the globus pallidus interna (GPI). The internal pallidum becomes overactive, and as a result the thalamus and cortical projections are overly inhibited resulting in slowing and poverty of movement.[1] This inhibition of the thalamus in Parkinson's disease is thought to occur either through the direct projections from the striatum through GPI, or indirectly mediated by the external globus pallidus and subthalamic nucleus. The net outcome is a decrease in the facilitation of normal movements and the development of unwanted movements.

The role of pharmaceutical treatment is the replenishment of dopamine by increasing the available substrate L-dopa.[4] However, in the absence of the available neurons in the substantia nigra, the benefits of L-dopa treatment can be minimal if any. Surgery has been directed toward the ablation of GPI. The creation of a lesion in GPI would reduce the inhibitory effects upon the thalamus restoring the facility of motion and the abolishment of dyskinesia.

Several ablative methods have been developed over the years for the destruction of GPI. Infarction of the pallidum by ligation of the anterior choroidal artery was undertaken by Irving Cooper in the early 1950s.[3] Unfortunately this procedure often resulted in hemiplegia and a mortality of 13%. This technique was replaced with more accurate stereotactic methods relying on stereotactic atlases and intraoperative ventriculography for target selection. The late 1940s and early 1950s witnessed the development of many ingenious and reliable stereotactic frames.

The advent of improved imaging of the central nervous system with computerized axial tomography (CT) in the early 1970s, and with magnetic resonance imaging (MRI) in the 1980s facilitated and improved the accuracy of the above procedures. With CT and MRI in particular, targets within the central nervous system including GPI can be identified and their three dimensional coordinates derived. Verification of these targets is performed intraoperatively with electrical simulation and microelectrode recordings.

Materials and methods

The authors have performed 26 stereotactic procedures for movement disorders including three bilateral procedures and repeat procedure for recurrent symptoms. There were 10 women and 12 men, with mean ages ± SD of 62±6, and 58±12 years respectively. The average duration of their disease up till surgery was 12 years. The indications for surgical treatment in Parkinson's disease were resistance to medical treatment or disabling dyskinesia, the absence of medical contraindications to surgery, the absence of cognitive dysfunction and preferably unilateral disease. Patients underwent a thorough preoperative evaluation consisting of neuropsy-

The IMS Education Fund has designated this article as the Henry Albert Presentation Award for October 1997.

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Surgical treatment of Parkinson's disease

chological testing, videotaping "on" and "off" drug, scoring on the Unified Parkinson's Disease Rating Scale (UPDRS), Hoen and Yahr staging and the Schwab and England Activities of Daily Living scale. The candidacy of a patient was mutually agreed upon by their attending neurologists, neurosurgeons and psychologist. The benefits and realistic expectations of surgery were discussed with the patient and family. Patients were given names and phone numbers of patients who had undergone this procedure. Reimbursement by the insurance carrier was obtained in all but two cases.

Technique

With the stereotactic frame applied, a thin slice MRI through and parallel to the anterior-posterior commissure line is obtained. The three dimensional coordinates of the target in GPI are then derived. A burr hole is made under local analgesia and microelectrode recordings obtained superficial to, through and beyond the target. Recordings obtained from Gpi, 3mm superficial to the target, reveal increased resting activity. Recordings 2mm deep show reduced activity, indicating passage through the nuclear complex of Gpi. The microelectrode is withdrawn and replaced with a stimulation electrode to corroborate the recordings. High frequency stimulation is also undertaken in an attempt to localize the optic tract relative to the target.

Radiofrequency lesions are made in a conical fashion the apex of which is caudal and the base rostral. After performing test lesions, permanent lesions are performed and stacked from the target to the AC/PC line. Throughout this procedure the patient's neurological status is monitored. Postoperative MRI is routinely obtained to confirm the location of the lesion within the desired target (Figure 1). Patients are discharged on the first through the third postoperative day and their medications resumed without change. Patients are followed sequentially after surgery, scored and videotaped as preoperatively.

Results

Twelve patients had at least six months of follow-up, and were scored by the same examiner using the UPDRS scale. While in the "on" phase of L-dopa treatment, the UPDRS-activities of daily living, motor score, rigidity, gait, bradykinesia and dyskinesia improved. In the "off" phase, activities of daily living, motor performance, rigidity, gait and bradykinesia improved after at least six months. Tremor responded to pallidotomy, but was often delayed taking up to two weeks or more for an appreciable improvement.

One of our early patients experienced dysphasia and mild hemiparesis as a result of a left-sided pallidotomy. This resulted in a prolonged hospitalization and the need for outpatient physical therapy. A second patient with severe dyskinesia was unable to tolerate fixation in the stereotactic frame, and the procedure had to be aborted. The patient is considering undergoing this procedure again.

Discussion

Favorable results with pallidotomy or thalamotomy in the treatment of movement dis-

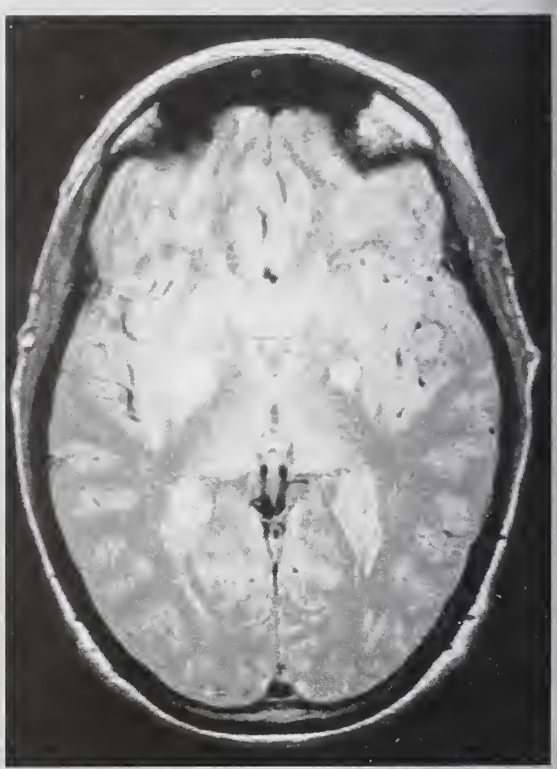


Figure 1 A postoperative MRI obtained three months following pallidotomy on the left side of the brain, and one day after pallidotomy on the right side. The lesion on the right side is associated with edema; the one on the left appears more discrete.

orders and Parkinson's in particular are not recent. Mundinger and Riechert in their experience with 1,500 cases of Parkinson's disease described an improvement in rigidity, tremor and bradykinesia in 92% of patients after surgery, which persisted in 82% at follow-up.[8] Bilateral procedures resulted in an improvement in 84% of patients after surgery, which persisted at follow-up in 59%. Their conclusion was that pallidotomy effected a greater improvement on rigidity (85%) than thalamotomy (64%), whereas the reverse was true for tremor.

Pallidotomy fell into disfavor until its resurgence and popularization by Laitinen et al.[6] In 1992 Laitinen et al published their results with 38 patients in whom pallidotomy was performed utilizing CT guidance. Tremor improved in 81% of patients, with rigidity and bradykinesia receiving excellent control in 92% of cases. Gait, speech and dyskinesia likewise improved without any psychological impairment. Six of the 38 patients were deseribed as having developed a visual field deficit, and one patient had a facial paresis. Of note is that drug treatment was reduced by 50 to 75% in patients postoperatively.

Similar experience with pallidotomy was also described by Iacono et al in their 126 patients.[5] Of note is that 58 patients underwent unilateral pallidotomy, whereas 68 patients underwent bilateral lesions, 49 of which were eontemporaneous. Again their results were very favorable in terms of the UPDRS scores and the elimination of akinesia and dyskinesia. Their experience is unique in terms of their advocacy of bilateral simultaneous pallidotomy.

Similar experience with pallidotomy has been reiterated more recently with publications by Lozano et al and Baron et al from Emory University.[2,7] These authors emphasize the importanee of intraoperative recording to identify the limits of the globus pallidus. The ventral, medial and posterior borders of GPI are to be identified if results with pallidotomy are to be consistent and reproducible. In addition the importance of an unbiased postoperative assessment to better judge the benefits of pallidotomy is underseored. Lozano and his group introdueed the potential benefits from thalamic and pallidal electrieal stimulation, particularly in patients who may prove candidates for bilateral proeedures. They advocated thalamotomy in cases with predominant tremor and pallidotomy for those dominated by several Parkinsonian features.

Our results reflect the experience of others. The best results were encountered in gait, bradykinesia, tremor and dyskinesia in the "on" phase. Improvement was noted in the contralateral extremities and to a lesser extent in the ipsilateral. These findings are not altogether surprising owing to bilateral projections from the globus pallidus to the thalamus and cortex. Rigidity and particularly freezing did not respond to pallidotomy to the same extent as other measurable UPDRS parameters. Our least favorable results were encountered in those with borderline neuropsychological testing, in whom compliance during the procedure was difficult.

Conclusion

Pallidotomy is a procedure that has proven effective over the years. The techniques of pallidotomy that are being utilized today are by no means identical to those described earlier. Imaging of the brain and electrophysiological recording are now able to identify and delineate targets more accurately then had been heretofore possible. Patient selection remains the most important variable to achieve excellent results. Pallidotomy will not replace drug treatment for Parkinson's disease. It is a procedure that can be undertaken safely in patients with severe dyskinesia, but without cognitive impairment and who harbor no medical contraindications to surgery. It seems likely that if its cost can be contained, non-ablative electrical stimulation of the thalamus and pallidum will play a greater role in the near future in the treatment of movement disorders. Until that time, ablative pallidotomy can achieve very rewarding results in controlling dyskinesia, bradykinesia and tremor.

References

References are available from the authors or the editors of *Iowa Medicine*. IM

Free rupture of a sinus of Valsalva aneurysm

● *David Hockmuth, MD; Mark Nelson, MD; Steven Phillips, MD*

Free rupture of a sinus of Valsalva aneurysms is an unusual occurrence. These aneurysms usually rupture directly into a cardiac chamber creating a fistula between a high and low pressure chamber which results in a large, symptomatic, left to right shunt. This complication commonly develops in adult life generally between the ages of 18 and 30 years of age. The patient often reports a sudden onset of chest or epigastric discomfort and dyspnea. A loud continuous murmur with a thrill over the precordium is common. The diagnosis is aided by clinical and echocardiographic findings and is established by aortography.[1-5]

Successful surgical obliteration of a ruptured aneurysm of the sinus of Valsalva results in dramatic improvement of symptoms. We report a case of a freely ruptured sinus of Valsalva aneurysm that presented without the usual findings and was successfully repaired surgically.

Case report

The patient is a 39-year-old male with a history of coarctation of the aorta and ventricular septal defect which were both repaired at the age of 13. On the day of admission, while working as a plumber, he experienced the sudden onset of shortness of breath, chest heaviness, nausea, vomiting and profuse diaphoresis followed by dizziness and syncope.

He was taken to an emergency room where evaluation revealed differential upper extremity blood pressures of 124/77 in the right arm and 90/77 in the left. There was marked neck vein distention, a healed median sternotomy scar and a regular heart rhythm with no murmurs, thrills or heaves. The abdomen was soft and lower extremity pulses were intact. An electrocardiogram demonstrated normal sinus rhythm, with a right bundle branch block and no acute changes. Echocardiography revealed normal left ventricular function and a dilated aortic root measuring 6.5 cm. A diagnosis of aneurysm of the aortic root was made with possible dissection.

The patient was transferred to our emergency room for further management. Computerized tomography of the chest with contrast revealed a dilated, dissected, 7 cm aortic root with compression of the main pulmonary artery and blood in the pericardial sac. Angiography demonstrated a left ventricular ejection fraction of 70%, normal coronary arteries, bicuspid aortic valve and an aneurysm of the aortic root. Because of the patient's symptoms and radiographic finding, emergency surgery was performed.

Emergency surgery performed

Operative findings revealed a large thrombus in the superior mediastinum that surrounded the ascending aorta and compressed the right atrium. The patient was placed on cardiopulmonary bypass via the femoral artery and right atrium and systemically cooled to 28°C. The aorta was cross clamped and the heart arrested with antegrade followed by retrograde cardioplegia. Bleeding was observed from the non-coronary sinus of the aneurysm when the clot surrounding the ascending aorta was removed. The aneurysm had ruptured freely into the pericardium but was contained by adhesions from his previous congenital heart surgery.

After opening the ascending aorta it was noted that the dissection penetrated into the annulus of the congenitally bicuspid aortic valve. The coronary arteries were not involved. There was marked clot formation in the dissection plane which was compressing the left atrium. The aneurysm was resected

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and a Bentall procedure performed with a mechanical valved conduit.

The patient made an uneventful recovery. The pathology report revealed non-specific cystic medial myxoid degeneration of the aortic wall.

Discussion

Aneurysm of a sinus of Valsalva is an uncommon anomaly occurring more often in males than females. The malformation consists of a separation or lack of fusion between the media of aorta and annulus fibrosis of the aortic valve. When rupture occurs it is typically into a cardiac chamber and not free.[1-4] It is rare for the left aortic sinus to be involved, with 5-15% of aneurysms originating in the noncoronary sinus and the majority originating in the right coronary sinus.[2]

The most common receiving chamber of an aorto-cardiac fistula is the right ventricle.[4] Occasionally, when the noncoronary cusp is involved, the fistula drains into the right atrium. Associated anomalies are common and include bicuspid aortic valves, septal defects and coarctation of aorta.

It is not clear whether the aneurysm itself is present at birth although the deficiency in the aortic media would appear to be congenital.[2] The reports of sinus aneurysms in children are infrequent. Aneurysmal dilatation of the weakened aorta is progressive and may not be recognized until the third or fourth decade of life when rupture into a cardiac chamber occurs.[3,4]

The unruptured aneurysm generally does not produce a hemodynamic abnormality although pressure on the intracardiac conduction system by unruptured aneurysms may be a rare cause of complete AV block. Myocardial ischemia may rarely be caused by coronary arterial compression. Rupture is often abrupt in onset and causes chest pain and a murmur of continuous arterial-venous shunting. This creates volume loading in both left and right heart chambers which results in heart failure.[2]

The presence of this anomaly should be suspected in a patient with a history of chest pain of recent onset, bounding pulses and a loud superficial continuous mummur accentuated in diastole when the fistula opens into the right ventricle as well as a thrill over the precordium. Echocardiography and/or cardiac catheterization are usually diagnostic.[5]

Our patient presented with signs and symptoms of an aortic dissection, tamponade and no mummur. This unusual presentation of a ruptured sinus of Valsalva aneurysm in our patient occurred because of the obliterated mediastinum from his previous open heart surgery. Patients that have correction of congenital heart defects such as coarctation with septal defects should probably be monitored long-term to be screened for the potential development of aortic root aneurysms. If our patient had been monitored and not assumed cured after his congenital heart surgery, he may have been diagnosed and treated electively thus avoiding emergency surgery with its associated risks.

References

References are available from the authors or the editors of *Iowa Medicine*. IM

RUSH

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Pick up after yourself

There is a plaque in one of the physicians' dressing rooms in Mercy Hospital that admonishes, "Your mother does not work here, so pick up after yourself." That speaks a lot for our entire society, i.e., that lack of responsibility of so many persons. Our cities, state and country are becoming veritable trash heaps. True, efforts are being made to recycle, to avoid littering, but there are far too many who haven't gotten the message, or choose to ignore it.

A couple years ago I had the pleasure to visit the Scandinavian countries and as we were touring the countryside surrounding Helsinki, Finland I noted the lack of litter. I asked our tour guide if there were strict anti-litter laws in Finland. Her reply was very illuminating: "We do not need them; from childhood on we are taught to not litter. Even a tiny scrap of paper is placed into a proper receptacle." Isn't that a marvelous discipline?

In the United States our national parks are becoming massive garbage dumps. Litter and vandalism are causing glaring eyesores. Millions of dollars must be spent annually to cope with irresponsible tourists. Yet the problem exists. And, our tourist attractions are not unique in this matter.

In the April 1997 issue of *Look Japan* there is a story of how tourist thoughtlessness is destroying the symbol of Japan, Mt. Fuji. Mt. Fuji holds a special place of importance for the Japanese. The Japanese have a mystic attitude about the mountain. Climbing to the summit is a religious experience. Millions of people travel up the slopes, and in July and August up to 150,000 climbers attempt to reach the 3,776-meter summit.

From a distance Mt. Fuji is beautiful, but not visible every day. Though I visited Japan several times during the Korean Conflict, I saw her beauty just one time. According to the story, the mountain is still as beautiful from the distance; but, on the mountain itself the environment is deteriorating due to so many hikers. Five hundred tons of garbage is collected each year; further efforts are being made to maintain the beauty.



MARION ALBERTS, MD

Millions of dollars must be spent annually to cope with irresponsible tourists.

We conclude that people are the same worldwide, unless proper training of environmental awareness begins in early childhood. As a profession trained in cleanliness, sterility and concern for others, we can encourage citizens in our communities to provide a beautiful environment for future generations. The message is "since your mother isn't with you all the time, pick up after yourself." IM

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AMAP

The AMA gives its stamp of approval on this physician-directed accreditation program

See page 354

1998 Annual Meeting is just around the corner

See page 345 for preliminary details on a weekend you won't want to miss

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1998 IMS Annual Meeting

This issue is dedicated to Dr. Marion Alberts, longtime scientific editor of *Iowa Medicine*. See pages 365-66 for his final column and farewell message.



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IMS *DEADLINE* news

November-December, 1997

Late-breaking news of interest to Iowa physicians

•**PHYSICIANS IN STRATEGIC PLANNING GROUPS** said they would like shorter, more digestible news from IMS, and the Board of Trustees has responded with a new communications plan to begin in January. The plan includes a redesigned *Iowa Medicine* and a new one-page *IMS Advocate* newsletter. Read the details on page 344.

•**CURTIS REYNOLDS, MD** is the newest member of the Board of Medical Examiners. Dr. Reynolds is director of primary care services at Mercy Hospital, Cedar Rapids. The IMS Board of Trustees recently met with BME representatives to discuss issues of concern such as the length of the BME's licensure process and treatment of impaired physicians.

•**DR. JOYCE BROTHERS WILL BE GUEST SPEAKER** at the IMS Annual Banquet on April 18, 1998 at the Marriott Hotel in Des Moines. Dr. Brothers will discuss ethics. The meeting begins on Friday, April 17 with an education session which will include Dr. Ira Byock, who will discuss end-of-life care and Dr. Robert Dreicer of the University of Iowa who will discuss pain management for terminal patients. Dr. Michael Kienzle will discuss telemedicine; Dr. John Renner will speak on alternative medicine. Watch your mail for more details!

•**IMS IS SEEKING NOMINATIONS** for its annual awards. The Physician Community Service Award honors an Iowa physician for uncompensated community service. The nomination deadline is March 1; the winner will be honored at the IMS Annual Meeting April 17-19. IMS is also seeking nominations for the Outstanding Medical Office Administrator Award. To nominate candidates for either award, call Chris McMahon at the IMS.

•**THE FIRST ANNUAL ORTHOPAEDIC SURGEONS** workshop on workers' compensation — "Treating the Injured Worker in Iowa" - will be Friday, January 23 in Des Moines. There is no fee for the symposium, which is sponsored by Des Moines Orthopaedic Surgeons. For more information, call Shelly Thompson at 515/327-5160.

•**THE AMA'S NEW PHYSICIAN CREDENTIALING PROGRAM** (AMAP) was officially introduced to the New Jersey health care community in late November. The American Medical Accreditation Program was launched in New Jersey with the assistance of the state medical society. IMS leadership is currently exploring possible AMAP implementation in Iowa. For more information on this new AMA program, see the feature story on page 354. The AMA hopes to implement AMAP nationwide by 2001.

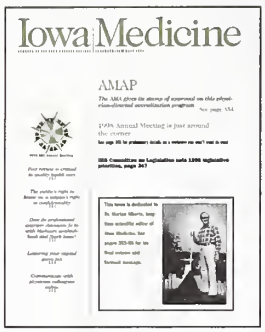
•**THANKS TO ALL THE PHYSICIANS WHO RESPONDED** to our request for information about personal experiences with managed care in Iowa. As of press time, about 230 physicians had responded. The information — along with 1997 House of Delegates directives — is being used to shape several managed care initiatives by the IMS in the 1998 Iowa Legislature. For more information on these and other issues IMS will address in 1998, see page 347.

•**THE AMERICAN MEDICAL ASSOCIATION** ranked eighth in a recent *Fortune Magazine* piece "Washington's Power 25", an article on groups which wield the most clout in setting public policy agendas. The article said, "Their clout springs from the sincere support they get from actual voters, not from the ability to buy the right politicians." Other organizations receiving high rankings included AARP (no. 1), the American Israel Public Affairs Committee (no. 2) and Trial Lawyers of America (no. 5).

For more information about any *DEADLINE* news item, call Chris McMahon at IMS headquarters, 515/223-1401 or 800/747-3070.

Iowa Medicine

JOURNAL OF THE IOWA MEDICAL SOCIETY NOVEMBER–DECEMBER 1997 / VOLUME 87 / 9



About the cover

This issue is dedicated to Dr. Marion Alberts, West Des Moines retired pediatrician and longtime Iowa Medicine *scientific editor. Since retiring, Dr. Alberts devotes much of his time to home gardening and serving as master gardener for Living History Farms, Des Moines.*

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Are your Medicare patients aware of restrictions on their freedom to contract privately with a physician? *Harold Miller, MD, IMS president*

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AMAP (the AMA's stamp of approval) 354

This AMA program is said to be "the one source for nationally standardized physician quality information." It is a voluntary, comprehensive, physician-directed accreditation program. *Jeanine Freeman, IMS staff*

Patient confidentiality and the Iowa Code 361

One Iowa physician discovered first-hand how to use the Iowa code when the public's right to know overrides a patient's right to confidentiality. *James Justice, MD*

An unusual cause of cecum perforation 363

This case report adds an unusual cause to the differential diagnosis of acute surgical abdomen with free air. *Philip Caropreso, MD; Steven Goetz, MD; Angela Gordon*

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Freedom to choose

This weekend my wife and I will welcome two friends for a visit. They are German citizens visiting the US for two weeks. They have a right and freedom to choose medical care not granted to our own senior citizens. This strange situation puzzled me and concerned me.

The Balanced Budget Act of 1997 states Medicare patients can arrange a private payment plan with physicians. This will only be allowed if the physician signs an affidavit promising not to bill Medicare for two years. This means no physician will be allowed to deliver privately contracted medical care. We now have a law, due to the Balanced Budget Act of 1997, that makes it impossible for our Medicare patients to contract privately with a physician. I do not feel our patients are aware of this abridgement of their freedom.

Most of you are aware there was an effort to make private contracting of medical services legal. This effort was twisted and convoluted until it was used as an effort to outlaw private contracting.

Our patients are concerned about this issue when it is carefully explained to them. I was discussing the law with two senior citizens at a recent public gathering. Their dismay was best exemplified by the statement from one lady who said, "Surely, you must be mistaken; I can still go outside the Medicare system and purchase whatever medical care I choose, wherever I choose?" Further discussion produced increasing concern from the elderly people surrounding me. They were alarmed to hear their freedom to make choices was limited.

There is a fundamental freedom issue lying before us—the ability of the elderly to privately contract for health care from a physician. This freedom is diminished and nearly eliminated by the recent Medicare laws. This lack of freedom was explained by one of my colleagues. He can't tell a patient a certain series of services are not covered by Medicare and at the same time feel he is able to provide the best service to the patient. He can no longer provide the service as a direct contract matter between himself and the patient. This is a very significant change in policy.

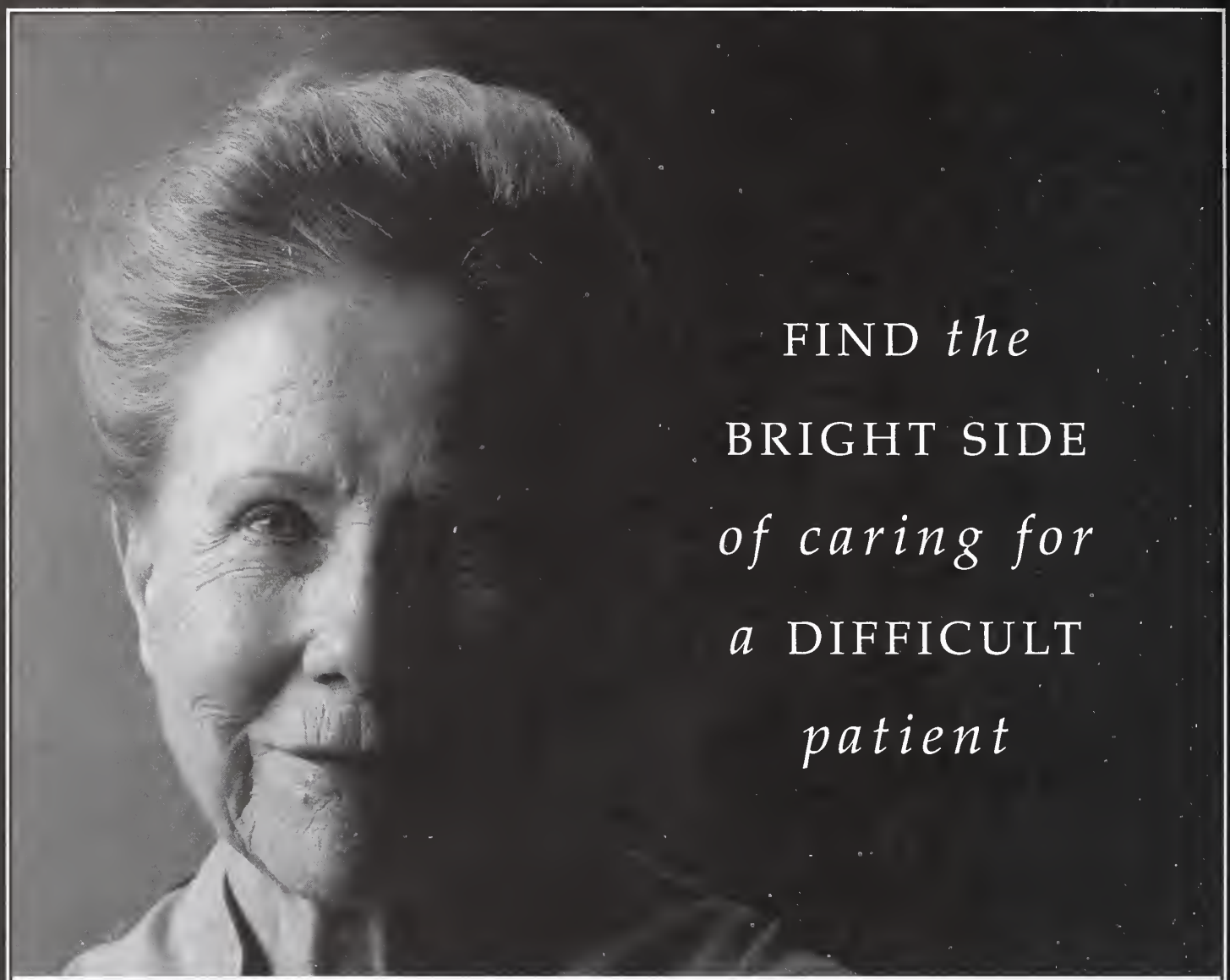
This issue deserves our continued attention not because of the limitation of medical freedom, but because of the unfathomable limitation of our patients' freedom.

I do not feel our patients are aware of this abridgement of their freedom.

In response to our strategic planning, changes are taking place in how the IMS communicates with its physician members. See page 344 for details. Dr. Marion Alberts, scientific editor of this journal, is to be commended for serving in that capacity for nearly 27 years. That translates to writing over 300 columns and reviewing at least that many scientific articles. Iowa physicians join me in saluting you, Dr. Alberts! IM



HAROLD MILLER, MD
IMS PRESIDENT



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New on the Net

Communicate with colleagues online

E-mail discussion lists are one of the most valuable professional resources on the Internet. Colleagues from around the world can conduct professional discussions by trading e-mail messages that are automatically broadcast to list members. Often this means you will receive a number of e-mail messages a day from other members of the group. These forums are also called listservs, discussion lists or mailing lists.

Mailing lists are dedicated to a particular interest or profession. For example, "OB-GYN-L" is a mailing list for medical professionals focusing on clinical, business, legal and ethical aspects of an ob/gyn practice.

You do not have to be an active participant of a discussion group by sending messages. In fact, it is best to observe messages for at least a week before sending any messages to the group. This gives you a chance to see what is being discussed and whether it's what you expected.

Some estimate there are 25,000 mailing lists on the Internet. A useful source for finding mailing lists is the Liszt Mailing List Directory (*www.liszt.com*). You can search for groups by keyword or by category. Liszt has a helpful introduction to mailing lists and provides information about each group, so you know what you're subscribing to before you begin receiving e-mail messages. Many medical sites, such as the Doctor's Guide to the Internet (*www.pslgroup.com/docguide.htm*), also provide directories of medical forums.

Subscribing to a mailing list requires sending a specific e-mail address to the administrator's e-mail address. Mailing list directories give instructions on how to subscribe to each group. You will often receive a welcome message from the group giving participation guidelines and instructions for removing your e-mail address from the list. Keep these instructions for future reference when you want to leave the group.



Linking IMS physicians to the information they need

Hot sites

Free MEDLINE: Access to MEDLINE is now free through the National Library of Medicine's (NLM) web site. Use PubMed (*www.ncbi.nlm.nih.gov/PubMed*), the NLM's publications search engine, to sift through nine million journal citations on MEDLINE and PREMEDLINE. You can also access Internet Grateful Med (*www.igm.nlm.nih.gov*), the NLM's comprehensive online search engine. Internet Grateful Med defaults to search MEDLINE, but you can choose to search other databases such as AIDSLINE, AIDSDRUGS, AIDSTRIALS, HealthSTAR, HISTLINE, OLD MEDLINE, DIRLINE and SDILINE. *www.nlm.nih.gov*

Wellmark: Wellmark Blue Cross and Blue Shield of Iowa recently launched a customer and provider service oriented web site. Preventive health advice, descriptions of insurance products and a directory of providers are available for customers. Providers can download provider enrollment applications and sign up for Wellmark's electronic commerce services. In the future, Wellmark plans to offer immediate eligibility and claim status information through its web site. Be sure to download Adobe's Acrobat Reader before going to Wellmark's site, so you can download PDF forms and instructions. See the October issue of *Iowa Medicine* for more information about PDF files. *www.wellmark.com* IM

IMS staff members are on the watch for sites that might interest Iowa physicians. Staff members visit all Hot sites *to make sure they have useful information and reasonable download times. Suggestions for* Hot sites *can be sent to Melanie Finke by e-mail at mfinke@iowamedicalsociety.org or by telephone at 800/747-3070.*

Distilled news is key to new IMS communications plan

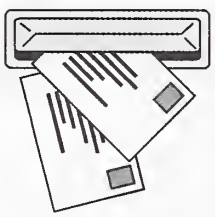
In January, physicians will see an early byproduct of the IMS strategic planning process — a revamped communications plan. Physicians say they want to know what IMS is doing, but want distilled news that can be quickly absorbed. In response, the IMS Board of Trustees approved a new plan that will do a better job of meeting information needs.

The plan has four components:

◆ *Iowa Medicine* — The all-new *Iowa Medicine* will contain shorter articles and more graphics. It will be published bi-monthly starting next year. In 1998, special issues will be devoted to students and residents and women physicians. There will be one more significant change — scientific material will no longer be included. During the past few years, there has been a steady decline in the number of scientific articles submitted to *Iowa Medicine*, and the new format recognizes that today's physicians get their scientific information from specialty journals.



◆ *IMS Advocate* — This one-page, gold-colored newsletter will use brief news items to communicate physician/patient advocacy efforts by IMS in the Iowa Legislature and with government, third party payers and others. It will be sent to practicing member physicians weekly during the Iowa Legislature and monthly the rest of the year.



Physicians want to know what IMS is doing, but they want distilled news that can be quickly absorbed.

◆ *IMS Executive Report* — This one-page memo from the IMS executive vice president will be faxed monthly to an abbreviated list of IMS leaders and stakeholders. It will be an insider's look at decisions which shape IMS programs and services. (Anyone who wants to be included on the list for the *IMS Executive Report* may contact Chris McMahon (Phone: 800/747-3070, fax: 515/223-8420; e-mail: cmcmahon@iowamedicalsociety.org.)



◆ IMSOnline — The IMS home page is evolving as the Internet becomes an increasingly valuable tool for communicating with physicians. IMSOnline is the best way for physicians to get instantaneous information on developments on Iowa's health care scene. There will be exciting additions to IMSOnline in 1998 as we begin taking advantage of the internet's capabilities. As part of the redesign, the IMSOnline Member Resources section will include a forum for members to give their feedback on important issues. Physicians will be able to key in their own comments — plus read the comments of their colleagues — at the touch of a button. These opinions will be shared with IMS leaders as they make policy decisions. IM



IMS Update

IMS offices up for election in 1998

Offices up for election at the Iowa Medical Society's Annual Meeting April 17-19 include (the length of each term is in parenthesis along with the name of the physician now holding the office):

PRESIDENT ELECT (1)—John Brinkman, MD
VICE PRESIDENT (1)—Jose Angel, MD
TRUSTEE (3)—Siroos Shirazi, MD
HOUSE SPEAKER (1)—Tom Throckmorton, MD
HOUSE VICE SPEAKER (1)—John Sutherland, MD
AMA DELEGATES (2)—Clarence Denser, Jr., MD; R. Bruce Trimble, MD; Donald Young, MD; and Jim Hubbard, MD, alternate delegate (AMA positions run January 1, 1999–December 31, 2000.)

Council seats up for election (all 3-year terms) are:

DISTRICT 1—Robert Kent, MD
DISTRICT 6—John Justin, MD
DISTRICT 9—Jay Heitsman, MD
DISTRICT 13—Linda Iler, MD

Judicial Councilors are elected by a district-wide vote of eligible IMS voting members. The names of physicians elected as Judicial Councilors will be submitted for confirmation by the 1998 House of Delegates. Details will be sent to county medical societies due to elect councilors in 1998.

News at a glance

The AMA is advising all member physicians that association dues used for lobbying activities are not tax deductible. As a result 29% of AMA dues for 1998 cannot be deducted as a business expense for federal income tax purposes. In addition, no portion of any dues paid to AMPAC or IMPAC can be deducted as a business expense on federal income tax returns. Neither IMS dues nor IMPAC contributions may be deducted as a charitable contribution. The non-deductible amount for 1997 was 29%; for 1996 it was 25% and for 1995 it was 33%.

Mark your calendars for Annual Meeting



1998 IMS Annual Meeting

"New Directions" is the theme of the Iowa Medical Society's 1998 Annual Meeting Friday, April 17 through Sunday, April 19 at the Mar-

News from Iowa Medical Group Management Association (IMGMA)

First IMS strategic planning retreat held

How can the Iowa Medical Society help Iowa physicians in their mission to offer quality care? How can IMS continue to effectively advocate for physicians in the Iowa Legislature and with third party payers? What services do physicians need to help them in their practices? How can IMS help preserve the autonomy and respect which physicians say their profession is losing?

These key questions and others were on the agenda as the IMS held its first strategic planning retreat in September. I was invited to attend the retreat to represent the IMGMA. The IMS Strategic Planning Task Force is comprised of representatives of a cross section of IMS member physicians.

Areas of specific focus during the weekend included:

1. Perceptions of Iowa physicians regarding the IMS and their connection to the organization;
2. Expectations of the IMS' role in assisting those physicians;
3. The values of Iowa physicians and the degree which the IMS is believed to reflect those values;
4. Satisfaction with the IMS and its program of work.

Saturday and Sunday sessions were devoted to discussion regarding assumptions about the future environment, key stakeholders of the IMS, the envisioned future of the IMS, core ideology and core purpose and values, opportunities to be explored, and challenges that threaten the IMS.

Additional retreats will be held in January and February. There will be a Town Meeting on Strategic Planning during the IMS Annual Meeting in 1998.

(This article was written by Bob Mason, vice president, Mercy Family Care Network, Mason City.)

IMS Update
continued

riott Hotel in Des Moines.

On Friday, we'll explore new directions in medical technology during a full-day program which expands on last year's highly successful Journey through Cyberspace. Special entertainment with a political flavor will be scheduled for Friday night's IMPAC reception.

On Saturday there will be a special Town Meeting on Strategic Planning which will give IMS members across Iowa a chance to have their say in the new direction of the IMS. Saturday night's Annual Banquet will feature an IMS trustee who uses his talents outside the medical field.

Watch future issues of *Iowa Medicine* for details.

Iowa delegation to introduce resolution

The Iowa Medical Society AMA delegation plans to introduce a resolution at the AMA interim Meeting in December regarding Medicare post payment audits.

In part the resolution states:

Resolved that the AMA work through regulatory and, if necessary, legislative channels to modify current Medicare post payment policies to allow physicians and carriers to informally resolve payment disputes based upon sample audit findings while preserving the physician's administrative and judicial appellate rights in the event a resolution satisfactory to both parties is not reached. IM

Focus on IMS Alliance

AMA-ERF—A legacy from one generation of medical professionals to another

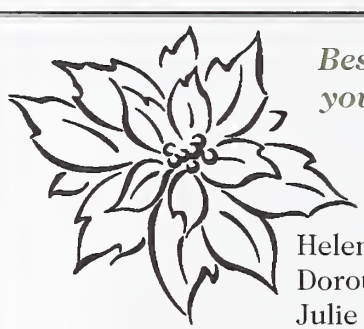
In 1950, medical schools were reportedly operating at a deficit of $10 million a year. Three years later, the AMA Board of Trustees asked the AMA Alliance for help. The AMAA urged its constituent auxiliaries to become involved in fund-raising.

The American Medical Association Education and Research Foundation (AMA-ERF) was born in 1962. Today, AMA-ERF is made up of several funds: 1) The Medical School Excellence Fund provides unrestricted grants to medical schools; 2) The Medical Student Assistance Fund provides money to schools for student loans, grants and scholarships; 3) The Development Fund is used at the discretion of the AMA-ERF Board for pilot and experimental health and medical programs; and 4) The Categorical Fund provides support for specific research areas.

Nationally with the help of the AMAA, the Foundation has raised over $65 million. Yearly contributions average $1.5 million.

The IMSA is raising funds to surpass last year's level of $15,477.41. Silent auctions, direct mailings, holiday sharing cards, phantom fund-raisers and Doctor's Day donations will benefit AMA-ERF. (The bulk of the funds raised in Iowa are channeled back to the UI College of Medicine.)

(This article was written by Cindy Ehrecke, IMSA president.)



Best wishes and a happy holiday season to you and your family from the Iowa Medical Society Alliance Board of Directors and past IMSA presidents.

AMA-ERF Holiday Share Card Contributors

Helen Austin	Janice Bannister	Barbara Bell
Dorothy Carpenter	Mary Conway	Ann Crouch
Julie Delperdang	Patti Dolezal	Audrey Eklund
Cindy Ehrecke	Mary Foley	Dianne Haas
Hermina Habak	Carmen Hernandez	Martha Holzworth
Geni Howard	Joan LeValley	Maureen Lyons
Cheri Maxson	Karen Messamer	Elaine Olsen
Pat Paulsen	Mary Jo Rater	Ruth Reed
Katie Robertson	Gail Sands	Barbara Savage
Diane Trimble	Erlene Veverka	Tess Young

Legislative Affairs

1998 IMS legislative priorities adopted

The IMS Executive Council met in November and approved, with some modifications, the legislative and regulatory recommendations of the IMS Committee on Legislation. Below are the highlights of the 1998 IMS legislative and regulatory policy positions.

Telemedicine: The 1997 IMS House of Delegates reiterated its concerns regarding the practice of medicine via telemedicine. The IBME intends to address telemedicine licensure issues on a case-by-case basis. IMS will monitor and assess state and national initiatives in the area of telemedicine licensure and will coordinate with the IBME on telemedicine regulatory issues.

Managed Care: The impact of managed care on patient eare and the health care delivery system in Iowa was a source of considerable discussion at all levels of the IMS policy setting tree. Managed care initiatives by IMS in the 1998 legislative year include:

- Seek regulatory redress through rulemaking of the Division of Insurance and the Department of Public Health consistent with the managed care resolutions adopted by the 1997 IMS House of Delegates.
- Continue negotiations on the Principles of Agreement developed originally in 1995 by the IMS, IH&HS and named third-party managed care entities, including Wellmark Blue Cross Blue Shield, John Deere and Principal.
- Develop informational and education material to assist physicians and consumers on how to register a complaint when dissatisfied with a managed care entity.

Medicaid Reimbursement for Physicians: Medicaid reimbursement rates for physician services have not increased for eight years (although there have been targeted increases for obstetrical and pediatric services). Data for this region of the country shows that from 1990 through 1995, non-physician payroll expenses for medical practices increased 51.4%; medical office expenses increased 71.5%; medical supply expenses increased 39%; and medical equipment expenses increased 29.9%.

IMS will actively advocate for an increase in Medicaid reimbursement for physicians. The Council on Human Services has included a 2% increase in physician reimbursement in its fiscal year 1999 budget proposal to the governor.

Physician Liens: The IMS introduced legislation into the 1997 General Assembly authorizing liens on physician services, thereby allowing payment of outstanding medical bills in the case of a financial recovery by an injured patient. The bill passed in the Iowa House and awaits debate in the Senate. IMS will actively pursue final passage.

Abortion Reporting: Last year, the Iowa General Assembly passed legislation mandating reporting to the Department of Public Health of both induced terminations of pregnancy and spontaneous terminations, or miscarriages, that occur prior to the 20th week of gestation.

Detailed reporting requirements are the same for both types of terminations. The IMS will work to alleviate the burdens of reporting for spontaneous terminations and, if necessary, a repeal of that portion of the law.

State Children's Health Insurance Program: The Balanced Budget Act of 1997 created the State Children's Health Insurance Program (SCHIP), Title 21 of the Social Security Act and appropriated $39.6 billion over

News at a glance

The 1997 IMS/IMSA Mini-Internship program is underway. The program will give legislators the experience of spending time in a physician's clinic. As of November 1, 10 legislators had expressed an interest in participating. We are seeking appropriate physicians from these legislators' districts. If you would like to volunteer to host a legislator, contact Paul Bishop at the IMS.

The impact of managed care in Iowa was a source of considerable discussion at all levels of the IMS policy-setting tree.

Legislative Affairs
continued

the next 10 years to support it. The federal law addresses insurance coverage for eligible children and sets parameters under which states may receive federal dollars and design their own programs of coverage. Iowa's allocation of federal SCHIP dollars is approximately $33 million, to be matched by a state appropriation of $11 million.

The IMS will work in coordination with the Iowa Academy of Family Practitioners, the Iowa Chapter of the American Academy of Pediatrics and others to assure a seamless system of access to health care for the greatest number of children in Iowa; to maximize federal dollars for the benefit of Iowa's children; and to provide coverage for categorically eligible children of limited means (133% of poverty) through Medicaid and for other eligible children up to 200% of poverty through a public/private partnership.

Hepatitis B Vaccinations for School Age Children: The new IMS Public Health Committee will assume jurisdiction over this issue to, among other things, coordinate with the Department of Public Health in examining the significant public health concerns associated with Hepatitis B and to recommend appropriate initiatives to address those concerns. The IMS at this time is not convinced that mandating immunizations is an appropriate public health response for Iowa.

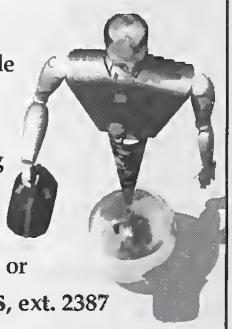
Licensure of Orthopedic Physician Assistants: The IMS Committee on Medical Service will assume jurisdiction over this issue to analyze the need for and the pros and cons of state licensure for OPAs and to make recommendations based on its findings.

Prudent Lay-person Standard: Medicare legislation has embraced a prudent lay-person standard to support payment for emergency room services. IMS supports implementation of this same standard in the rules of the Division of Insurance and the Department of Public Health. The Insurance Division is currently considering adoption of this standard for HMOs in Iowa.

Sales Tax Exemption for Iowa's Private Hospitals: IH&HS is actively advocating repeal of Iowa's sales tax for all private hospitals, thereby placing hospitals, regardless of their tax status, on equal par with governmentally controlled hospitals which now do not pay a sales tax on their goods and services. Hospitals in states bordering Iowa also do not tax sales of hospital goods and services.

IMS will "monitor with concern" this proposal and will be prepared to highlight for legislators the competitive disadvantages for physicians' offices, particularly those not owned by hospitals, if hospitals are not required to pay taxes on those same goods and services that are taxed to physicians' offices; to evaluate favorable amendments that might be negotiated for physicians; and to more fully assess membership views on this issue.

Workers Compensation and Provider Balance Billing: The Iowa State Bar Association is considering legislation that would preclude health care service providers from balance billing employers for that portion of their charges for medical services to worker compensation patients when the employer's insurance carrier fails to pay the full bill. IMS opposes this provision. IM

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DATA & TECHNOLOGY

CHMIS update

The original mission of CHMIS was to establish an integrated electronic health management information system for Iowa that would be responsive to the changing needs of all Iowans by: (1) reducing the cost, improving the efficiency and simplifying the processing of claims and payment transactions; (2) providing an efficient system to share information on appropriateness, efficiency and effectiveness of health care services to improve the quality of Iowa's health care system; (3) providing data for research; and (4) supplying information for educational purposes to enhance the health status of Iowans.

The CHMIS Governing Board is working to accomplish this mission, which most agree is still viable. However, some want to shut down CHMIS and transfer its activities into a department within state government.

As a countermeasure, the Board gave consent to a work plan that would guide CHMIS efforts through 1998. The plan seeks to acquire data from existing sources to publish informational and educational reports; research, compile and implement a consumer education strategy; establish an integrated electronic data interchange (EDI) system that is consistent with national standards mandated in the Health Insurance Portability and Accountability Act (HIPAA), scheduled for implementation in 2000; and serve as an implementation test state for these standards.

Meantime, CHMIS continues to search for long-term funding sources. The 1997 Iowa Legislature appropriated $200,000 through June 30, 1998. Speculation has centered on at least three possibilities: federal government funds to implement HIPAA; a grant from the John Hartford Foundation for studies on aging; and continued appropriations from the state legislature.

Are others successful?

Most community health management information systems have dissolved or undergone extensive metamorphosis. Originally defined as an all-inclusive, separately developed network linking all providers and patient information in a huge data base, most CHMIS projects could not overcome several road blocks.

Provider and payer organizations were not willing to surrender proprietary data to outside parties. Patient confidentiality and security concerns bogged down many efforts. The cost of building a huge centralized data repository doomed other systems, including Iowa's.

Most systems that are still active are gravitating toward intranets. Intranets are private computer networks that use Internet protocols and Internet-derived technologies, i.e., web servers and World Wide Web browsers. This approach is more cost effective because networks utilize the Internet to share information. This allows one organization's data base to be accessed by other organizations. A centralized data repository is not required.

More physicians use EDI

One component of the Iowa CHMIS mandated Iowa physicians send their insurance claims electronically. While still contained in the Iowa law, implementation has been put on hold. Meantime, physicians have been increasing their use of this technology.

In 1995, physician offices nationally submitted 27% of insurance claims electronically; in 1996 it was 35%. It is expected in 1997, 38% of insurance claims will be submitted electronically by physician offices. However, this lags behind other health care providers. Hospitals submitted 82% of insurance claims electronically in 1996. Pharmacies submit 83% of claims using EDI. IM

Commercial insurance companies accept only 37.5% of medical claims electronically; HMOs accept 18%. Both lag significantly behind Medicare and Medicaid which nationally receive 83% of claims electronically.

For more information, call Ed Whitver, vice president of administration, 515/223-1401 or 800/747-3070.

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Practice Management

Professional courtesy discounts

Editor's note: This information was provided by David Glaser, an attorney with Fredrikson & Byron in Minneapolis.

A policy of offering a courtesy discount to physicians may violate the Medicare antikickback and Stark laws. The antikickback law makes it a crime to "offer or pay any remuneration directly or indirectly . . . to refer an individual to a person for the furnishing . . . of any item for service for which (payment may be made under the Medicare or Medicaid program)." In essence, the law seeks to prohibit any offer of money, a good or a service if the payment is made to encourage a referral.

Some court cases have shed light on how the courts interpret the law. Perhaps the most significant interpretation is the *Greber* case, which articulated a rule called the "one purpose test." Under the one purpose test, an arrangement violates the law if one purpose of the arrangement is to influence referrals. Under this approach, if there are 10 legitimate reasons for a transaction, but one additional reason is that it may encourage physicians to refer patients, the transaction is illegal.

A regulator could conclude one reason a physician offers free or discounted care is to generate goodwill of physicians who are in a position to refer their patients to the physician. Part of the problem is the regulator may believe one purpose of the free or discounted care is to encourage referrals even if that is not the case. The regulator may not see any other legitimate explanation for the policy.

Specialty providers are at highest risk of being accused of violating the antikickback statute. Every physician who receives a courtesy discount is in a position to refer to a specialist. By contrast, if a family practitioner offered courtesy discounts it is slightly less likely other physicians would be in a position to refer patients to a family practitioner.

Stark creates even larger problems with professional courtesy discounts. Stark prohibits a physician from referring a patient to any entity for a "designated health service." The goal of the law is to prevent a physician's judgment from being affected by any financial benefit. For this reason, Stark does not require proof of intent to induce referrals in order to establish a violation of the law. Unless the financial relationship qualifies for one of the law's exceptions, as long as the physician has a financial relationship with the entity and is referring a patient to that entity for the provision of a designated health service, the referral is illegal, and both the physician and the entity are liable for civil monetary penalties of

News at a glance

The IMS-sponsored HCFA Documentation & Coding Single Organ System Exam Criteria programs held this fall via the Iowa Communications Network were highly successful. Approximately 1000 physicians, office managers and staff participated in nine seminars held across Iowa. The new documentation and coding guidelines will go into effect January 1 and will change the way every physician documents the physical exam portion of the patient encounter.

Designated health services

- **Clinical laboratory services**
- **Physical therapy services**
- **Occupational therapy services**
- **Radiology, including magnetic resonance imaging, computerized axial tomography scans and ultrasound services**
- **Radiation therapy services and supplies**
- **Durable medical equipment and supplies**
- **Parenteral and enteral nutrients, equipment and supplies**
- **Prosthetics, orthotics and prosthetic devices**
- **Home health services and supplies**
- **Outpatient prescription drugs**
- **Inpatient and outpatient hospital services**

Practice Management Workshops for You

New programs coming in 1998

January	**1998 CPT Coding**	**March**	**Compliance Programs**
	Fee Schedule Analysis		**HCFA Documentation Guidelines for Single Organ System Criteria & Audit Tool**
February	**How to Collect for Control**		
	Statewide E & M Rap Group		

Watch your mail for the 1998 practice management quarterly calendar. All of the above workshops contain new information, except How to Collect for Control.

Practice Management

continued

Midwest Medical Insurance Company Focus on Risk Management

Jousting revisited: don't fall into this liability trap

A 22-year-old woman delivered a large baby with difficulty and postpartum complications. The birth was attended by the on-call physician, whom the patient had never met. The woman suffered several perineal tears. On her first postpartum check she was seen by her regular physician, Dr. A. "Who delivered your baby?" Dr. A asked. "Dr. B," the patient replied. The physician then asked, "What on earth did she do to you?" Although nothing negligent had happened during the delivery, the alarmed patient sued the on-call physician. In the complaint, the lawyer cited Dr. A as an "expert willing to testify" that Dr. B was negligent.

At one time or another, you may have been tempted to chastise or criticize a colleague. Making critical comments about another provider's care, either directly to the patient or in the medical record, is called "jousting." When one physician openly criticizes another, both are at increased risk for malpractice. MMIC has had cases where one physician's offhand criticism of a previous physician's care or diagnosis led to the patient bringing the claim against the prior physician.

Some tips to help you avoid jousting:

- Be aware of your body language. Frowning, sighing, rolling your eyes or shaking your head are signals the patient may interpret as critical or negative.
- Avoid giving the patient the impression their current condition is much more difficult to manage because another physician has preceded you in their care (i.e., care was inappropriate).
- Wait until you have the facts before drawing conclusions. Review the medical record; patients often distort or misstate facts in recalling events or test results.
- Be objective in your own documentation. Do not criticize the conduct or treatment of other providers in the patient's chart.
- Ensure your charting adequately reflects the care and treatment you are providing.

Certainly there are cases where a provider may legitimately believe another's care was inappropriate, even negligent. If a surgical instrument was left inside a patient, or an obvious fracture missed on an x-ray, the patient needs to be told of the findings. It is never advisable to be dishonest with a patient or try to cover up or minimize another's clear error. However the consulting physician should be very careful to obtain all the facts before reaching a conclusion.

For more information contact Lori Atkinson, MMIC risk management supervisor, Midwest Medical Insurance Company, West Des Moines Office, PO Box 65790, West Des Moines, Iowa 50265; 800/798-9870 or 515/223-1482.

up to $15,000 per claim. A government regulator probably would conclude the treating physician has created a "financial relationship" with a physician when the treating physician provides free or discounted care to that physician.

For Stark purposes, a financial relationship includes "any remuneration, directly or indirectly, overtly or covertly, in cash or in kind." Under this broad definition, any in kind benefits, including free or discounted care, would create a compensation arrangement. Even if the free or discounted care does not influence the recipient to make a patient referral to the treating physician, both will have violated Stark if the recipient of the free care refers any patient to the treating physician for the provision of a designated health service.

Stark defines the term "referral" broadly. Merely creating a plan of care for a patient can be considered referring the patient for all care under the plan. Since lab, radiology, inpatient and outpatient hospital services and orthotics and prosthetics are among the designated health services, nearly every physician who creates a plan of care or specifically refers patients to the treating physician refers some patients for designated health services.

Unfortunately, none of Stark's exceptions cover a courtesy discount. As a result, there is a real risk courtesy discounts could be attacked under Stark. While there have not been any suits filed by the government using Stark, it is likely this will change.

Professional courtesy discounts are becoming less of an industry norm, partly because of the significant risks posed by Medicare anti-kickback laws. As more practices realize the added risk posed by Stark, it is likely policies for granting professional courtesy discounts will become more rare. While there have been some rumblings in medical associations about procuring a legislative exception to Stark for professional courtesy discounts, no concerted effort has been mounted, and any such effort would probably be unsuccessful. IM

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AMAP

Touted as "the one source for nationally standardized physician quality information," the American Medical Accreditation Program, or AMAP, is a voluntary, comprehensive, physician-directed accreditation program that measures and evaluates individual physicians based on nationally-recognized standards, criteria and peer performance.

The American Medical Accreditation Program is the result of a two-year study conducted by the American Medical Association. This new program encompasses five primary components:

1 Individual physician credentials (license, education, training, work experience);

2 Personal qualifications (ethical behavior, CME participation, involvement in peer review, participation in self-assessment);

3 Environment of care (office facilities, office procedures and policies, staffing and staff performance, medical records);

4 Clinical performance (care and guidelines compliance for preventive care, early detection of disease, appropriateness of services provided);

5 Patient care results (effectiveness established through clinical outcomes, cost, health status, patient satisfaction).

Unique features of AMAP

AMAP is an AMA service, but a physician need not be an AMA member to use it; non-AMA members, however, will pay a higher price for AMAP accreditation. Another unique feature of AMAP: its governing body, comprised primarily of physicians, also includes stakeholder groups, such as consumers, employers, health plans and hospitals. AMAP advisory committees are composed almost exclusively of physicians from state and county medical societies and national specialty groups.

The AMA cautions that AMAP is not only credentials verification, not a minimum standard, not only an office review and not a substitute for specialty board certification. To the contrary, the AMA wants to assure health providers and payers alike that an AMAP-accredited physician has met the highest national standards for training, behavior, practice and patient care.

Over time, AMAP will tailor its office review criteria to better reflect differences in the practice of individual specialties.

IMS connection to AMAP

AMAP will be implemented by the AMA on a state-by-state basis, working closely with state and local medical societies. AMA hopes to be fully operational nationwide by the year 2001. The IMS Board of Trustees has appointed a task force of its members to serve as the AMAP implementation committee for this state. Iowa is connected to AMAP in another way: the Iowa Foundation

JEANINE FREEMAN
Ms. Freeman is vice president of public policy and advocacy at the Iowa Medical Society.

for Medical Care recently was awarded an AMAP contract to develop the software component of its environment of care survey.

The following questions and answers are provided by William Jessee, MD, AMA's vice president for quality and managed care. This information first appeared in the September 1997 issue of *Illinois Medicine.*

Where will AMAP get its information about physicians?

AMAP will initially compile information from two sources—the physician's application and the results of a review of the physician's practice. The application will be similar to current applications for participation in health plans or membership in hospital medical staffs. All of this data will be in a single electronic file that will be made available to hospitals and health plans in which the physician wishes to participate. AMAP will eventually include data on clinical performance and patient care results.

Will AMAP credential physicians?

AMAP itself will not credential physicians. AMAP, however, will be a single source of information about physician credentials and qualifications that can be used by any hospital or health plan that participates.

What exactly will participating physicians need to do?

The physician who chooses to participate in AMAP will complete one application for accreditation every two years and undergo one review of his or her office. This information can then be provided to every hospital and every health plan that agrees to use AMAP information.

How is AMAP different from physician profiling, in which the public can access information like malpractice records?

Specific profile data about individual physicians will not be made available to the public. The AMAP physician portfolio of information will be provided only to physicians and participating hospitals and health plans.

What control will physicians have over the collection and interpretation of information about their practices?

Physicians will be provided with uniform feedback on their own clinical performance and patient care results and can work with their county and state medical societies and specialty societies to ensure that such information is interpreted accurately.

How will one set of practice standards reflect the practice of medicine when specialties vary significantly?

AMAP accreditation will reflect standards that are not specialty-specific but that describe the characteristics of a quality physician, regardless of specialty. Over time, AMAP will tailor its office review criteria to better reflect differences in the practice of individual specialties.

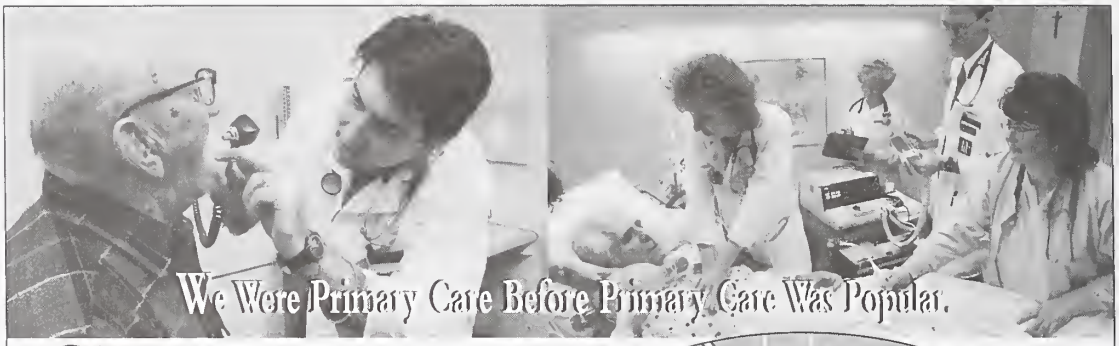
How does AMAP compare with the National Practitioner Data Bank?

The National Practitioner Data Bank is simply a repository of information on disciplinary actions and malpractice claims. AMAP is a standard-setting program that evaluates physician qualifications and performance against national standards, renders an accreditation decision and provides a comprehensive report to physicians so they can continuously improve the quality of their patients' care and their office operations.

What incentives do MCOs have to accept AMAP?

MCOs will use AMAP because it is much cheaper for them to purchase information from a single source than it is to collect it themselves. AMAP will meet all requirements placed on managed care plans by the National Committee for Quality Assurance and the Joint Commission for the Accreditation of Healthcare Organizations. IM

AMAP advisory committees are composed almost exclusively of physicians from state and county medical societies and national specialty groups.



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Peer review is critical to quality health care

On the Legal Front



Jeanine Freeman, JD

The information in this column is not intended to be legal advice. If you have specific questions or concerns, contact your attorney.

Peer review is recognized by Iowa statutory and case law as critical to quality health care and protection of peer review records and proceedings against public release and civil liability as essential to assuring full and effective participation of practitioners in the peer review process. The extent to which peer review records, proceedings and participants are protected under the law, however, is not as clear.

Common law affords neither evidentiary privilege to nor liability protection for participants in peer review. Peer review for evidentiary and legal liability purposes is specifically defined and governed by the Iowa Code.

A person is not civilly liable for acts, omissions or decisions made without malice when serving on a peer review committee, nor is a person liable for filing a report or complaint with a peer review committee or for providing information, including privileged matters, to the committee. A peer review committee can be one or more persons acting in a peer review capacity for a professional society, a hospital medical staff or a medical office or clinic that follows a formal peer review process.

A person is not civilly liable for acts, omissions or decisions made without malice when serving on a peer review committee.

Facts establish malice; for instance, peer review conducted as a subterfuge for hurting a competitor likely rises to the level of malice and, if done so in concert with others, may be an outright violation of the antitrust laws.

Peer review is the evaluation of professional services by a person licensed to practice a profession. Peer review need not be directed to a specific licensee in order to be peer review. The overriding purpose of peer review—namely, to assure quality through critical analysis of medical care—aids in identifying legitimate peer review. To secure protection, peer review proceedings should be identified as such by providers.

Records of a peer review committee are privileged and confidential, are not subject to discovery, subpoena or other means of legal compulsion, and are not admissible in any judicial or administrative proceeding.

Iowa law specifically precludes access by the Board of Medical Examiners to peer review records, but the BME can discover information otherwise available even if such evidence is also part of the peer review committee's files.

Peer review records include complaints, investigative files and reports relating to licensee discipline or professional competence in the possession of a peer review committee. Persons at a peer review committee meeting shall not be permitted to testify in any judicial or administrative proceedings as to the findings, recommendations, evaluations or opinions of the peer review committee. IM

Ms. Freeman is vice president of public policy and advocacy at the Iowa Medical Society.

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Capital gains . . . a strategic opportunity

PERSONAL FINANCIAL STRATEGIES

In last month's column, I discussed some of the tax law changes that could affect your financial planning. This month I'll take a closer look at lowering the capital gains tax. Of all the changes made in the Taxpayer Relief Act of 1997, much of the discussion revolved around a lower capital gains tax which Congress believed would motivate taxpayers to sell securities and remit taxes to the treasury. The politicos were probably right, because with the tax change, taxpayers have an opportunity to change some strategies.

Many people are holding onto low-basis stock or property because they don't want to pay taxes on the sale. Because of this, they don't have much of an asset allocation strategy, having much of their portfolio concentrated in one or two stocks. With the lower capital gains tax, they can now consider selling some of that stock to diversify.

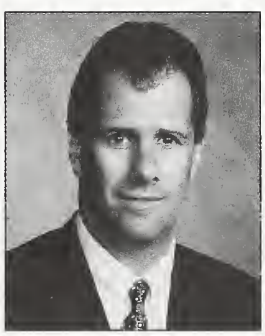
Asset allocation can take on a different look with a widened tax-rate differential between ordinary income and capital gains. Now that interest and dividends will be taxed at an even higher rate than most appreciated assets, asset allocation strategies could be slanted more toward total return as opposed to income. Even for the person who is needing a certain income stream from their portfolio, a well-balanced portfolio can generate more income from growth as opposed to income and dividends. This is particularly important if income is necessary from non-qualified assets.

Asset allocation can take on a different look with a widened tax-rate differential between ordinary income and capital gains.

For those who have both qualified (tax-deferred) and personal assets, the need for strategically placing the assets takes on even more importance. With higher taxes on income and dividends, placing those assets with fixed-income in tax-deferred accounts and growth-oriented assets in personal non-qualified accounts makes the most sense.

Another strategy that deserves attention is mutual fund selection. The lower capital gains tax is applied to assets that are held for more than 18 months. Short-term capital gains taxes are higher under the new law. Selecting a mutual fund must now include an assessment of the funds portfolio turnover. If a fund is doing a lot of active trading, it's likely there will be higher taxes due to short-term capital gains. This is a tax bite that hurts because it's one the fund manager is creating and one over which the consumer has no control. Buying and holding indexed and asset class funds with little turnover will offer significant advantages. These funds typically have less than 10% turnover compared to many actively managed funds with turnover ratios in excess of 100%.

Opportunity comes with every change. Take the time to understand the changes and what opportunities they present for you to change your strategy and improve your financial planning and management process. IM



JERRY FOSTER

Jerry Foster is the founder and president of Foster Capital Management, a fee-based financial advisory firm endorsed by the Iowa Medical Society. Mr. Foster can be reached at 1-800/798-1012.

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Patient confidentiality and the Iowa Code

GUEST EDITORIAL



JAMES JUSTICE, MD

We all understand the need for patient confidentiality. However, physicians frequently become aware of reportable diagnoses in our patients. Recently, I was involved in a case where I felt concern for public safety should override patient confidentiality. Unfortunately, I had no idea of my options.

An elderly patient of mine was hospitalized by his family; it was a 48-hour legal commitment to determine mental competence. Psychiatric and psychological evaluation determined the patient was competent. However, the patient failed the formal driver safety test.

I contacted the patient and relayed the test results to him, advising him not to drive. I told him failure to follow this advice could result in bodily injury and/or death to himself or others. I explained he could be sued if he failed to follow this advice. The patient indicated he understood this information.

I documented the phone call carefully in the medical record. I sent a registered letter reiterating the information and invited the patient to contact me if he required clarification. The green postcard which he signed upon receipt of the letter was returned to the office, stapled to a copy of the letter and filed in his chart.

At this time I experienced a great deal of emotional conflict. I did not want this elderly gentleman to injure or kill a child walking to school. I really felt that I should report this situation to civil authorities but did not want to risk a possible lawsuit for violating my patient's right to confidentiality. Neither did I want to be sued for failing to report this situation to the proper authorities.

Erika Linden, director of risk management and education for Integra Health, supplied the answer to my concerns with Section 321.186 of the Iowa Code which states a physician may report and be protected from liability. Upon receiving this information, I sent a non-judgmental letter with a copy of the medical report to the Driver's Licensing Bureau. A copy of the letter and the report were also was sent to the patient.

I have no idea what has been done with this information and I don't know if my patient is still driving. I don't have any control over either of these factors. However, I am now at peace with myself because I feel I have done the right thing and have done all I could to prevent a bad outcome.

Recently, I was involved in a case where I felt concern for public safety should override patient confidentiality.

If an accident occurs, an attorney could still file a lawsuit against me. However, the documentation of the actions I took should protect me against a significant jury award.

I encourage Iowa physicians to use the Iowa Code when you determine the public's need to know overrides a patient's right to confidentiality. Use it to protect yourself. IM

Iowa Code, Section 321.186 excerpted reads: "A physician may report the identity of a person who has been diagnosed as having a physical or mental condition which would render the person incompetent to operate a motor vehicle in a safe manner. The physician shall make reasonable efforts to notify the person in writing. A physician making a report shall be immune from any liability, civil or criminal, which might otherwise be incurred or imposed as a result of the report."

Dr. Justice practices internal medicine with Integra Health in Cedar Rapids.

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The Journal
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An unusual cause of cecum perforation

● *Philip Caropreso, MD; Steven Goetz, MD; Angela Gordon*

Common causes of acute surgical abdomen include biliary colic, perforated gastric or duodenal ulcers, acute intestinal obstruction with strangulation, acute perforated appendicitis and perforated acute diverticulitis. When free air is demonstrated on abdominal x-rays, the perforation of a hollow viscus is a near certainty. This report of a case adds an unusual cause to the differential diagnosis of acute surgical abdomen with free air: perforation of the cecum secondary to a retained oral potassium supplement.

Case report

A 65-year-old white man underwent a left total knee arthroplasty without complication. On the fourth postoperative day, he had complaints of abdominal pain and fever. After episodes of nausea and vomiting, a diagnosis of gastroenteritis was made. The patient's diet was reduced to clear liquids, and the patient was treated with Compazine. His other medieations included Accupril, K-Dur and Maalox.

Throughout the fifth postoperative day, the patient's pain increased and was most severe in the right lower quadrant. The patient had associated tenderness, guarding and rebound tenderness. Flat and upright abdominal x-ray studies demonstrated free intraperitoneal air.

A diagnosis of an acute surgical abdomen secondary to a perforated hollow viscus was made. An exploratory laparotomy revealed a micro perforation in the anterior cecum, which was the source of diffuse peritonitis. There was no obvious diverticular disease or mass lesion in the colon. The cecum was resected and an ideal ascending colostomy was made. The specimen revealed two oblong, white pills within the ulcerated mucosa of the cecum. The perforation was at the site of these pills. The medication was determined to be K-Dur, an oral potassium supplement, which the patient had been taking postoperatively.

The pathologic findings included a 17 cm segment of ascending colon with the serosa covered by a dull green/tan fibrous exudate. A gross area of perforation was present in the area of erosion. Sections from the cecum revealed areas of mucosal ulceration with acute inflammation and necrosis extending into the bowel wall. The area of perforation was microscopically confirmed.

The patient made a gradual recovery from his operative procedures and was discharged from the hospital.

Discussion

The abdominal x-ray was used to determine perforation of a hollow viscus. It showed free intraperitoneal air. The most common cause of pneumoperitoneum is free air which enters during a laparotomy or laparoscopy. The patient had not undergone an abdominal surgical procedure. Perforation of a gastric or duodenal ulcer, particularly in a postoperative surgical patient, is the most common pathologic cause of pneumoperitoneum.[1] The second most common cause of free air is perforation of the colon, which is usually seen in diverticular disease or malignancies.[2] The patient had no prior history to suggest either of these etiologies.

Perforated diverticulitis usually occurs in the sigmoid colon. Besides carcinoma of the colon, other diseases such as ulcerative colitis, volvulus, foreign body penetration and stercoral ulcers can result in perforations of the colon with free air.[2]

Perforations of the colon caused by a pill are rare. Nonsteroidal anti-inflammatory drugs have been implicated in injuries to the eolon, and oral potassium supplements have been associated with an increased frequency of small bowel lesions. It is known that high,

The IMS Education Fund has designated this article as the Henry Albert Presentation Award for November–December 1997.

Philip Caropreso, MD
Steven Goetz, MD
Angela Gordon
The authors are associated with the departments of surgery and pathology at Mason City Clinic, PC and North Iowa Mercy Health Center, Mason City.

An unusual cause of cecum perforation

continued

localized concentrations of potassium ions are injurious to the gastrointestinal mucosa, but the precise mechanisms of the pathophysiology of these injuries have not been thoroughly studied.[3] K-Dur is a tablet formulated to provide a controlled rate of release of microencapsulated potassium chloride, thereby minimizing the possibility of a high, local concentration of potassium ions near the gastrointestinal mucosa. In this case, the K-Dur pills transited the entire upper gastrointestinal tract to reside within the cecum. They were unaffected and unchanged by any digestion, events which are unusual.

Perforations of the small intestine associated with wax matrix potassium chloride preparations have been previously reported.[4,5] No reports of perforation of the cecum brought about by microencapsulated potassium chloride could be found in the surgical literature.

Conclusion

If a patient taking potassium chloride supplements presents with symptoms of vomiting, abdominal pain, distension or gastrointestinal bleeding, the medication should be discontinued immediately. The possibility of ulceration, obstruction or perforation should be considered for both the upper and lower gastrointestinal tracts. If a patient has physical findings indicating an acute surgical abdomen, perforation of the colon secondary to a potassium chloride supplement should be remembered as a complication of these medications. This cause should be included in the differential diagnosis of peritonitis secondary to perforation.

References

References are available from the authors or the editors of *Iowa Medicine*. IM

Early evaluation and treatment of the chronic pain patient*

Millions of people suffer from chronic or intractable pain. Persistent pain varies in etiology and presentation. In some cases, symptoms and signs may be evident within a few weeks to a few months after the occurrence of an injury or the onset of disease. The cause of pain is not always known or apparent. For many patients, initial evaluation and treatments effectively relieve pain that might otherwise become chronic.

Like many illnesses that at one time were not well understood, pain and its many manifestations may be poorly treated and seriously underestimated. Inappropriately treated pain seriously compromises patients' quality of life, causing emotional suffering and increasing the risk of lost livelihood and social integration. Severe chronic pain affects both the pediatric and adult populations and often leads to mood disorders, including depression and in rare cases, suicide.

This consensus statement applies to patients who have chronic or intractable pain. In some cases, the underlying cause of the pain may remain unclear, or misdiagnosis may occur. Both situations can cause patients even greater despair and lead to possible overuse of health care resources.

Each physician bears the responsibility to evaluate and treat persistent pain as a serious medical condition. Principal treatment physicians must approach each patient with respect and urgency and provide appropriate and timely referrals to a pain medicine specialist when primary medical care has not been effective. Such referrals are appropriate because pain medicine specialists can provide a more advanced level of treatment to patients suffering from chronic or intractable pain.

The diagnosis and management of chronic pain is a complex process requiring intensive, comprehensive and interdisciplinary services for optimum treatment outcomes. Thorough and effective pain evaluation and control must be the primary goals. These goals must be met within a few weeks to a few months of onset or initial occurrence in order to prevent progressive pain, associated morbidity and increased costs. As physicians, we are trained to preserve patients' quality of life and relieve their pain and suffering. We must use all available resources to achieve these goals for our patients.

**A consensus statement from the American Academy of Pain Medicine, 1997.*

Three significant holidays

It is appropriate three significant holidays occur in successive months, four weeks apart—Thanksgiving, Christmas and New Year's. Furthermore, in our part of the world the holidays occur during the bleak days of winter. By the last of November the cold weather has begun to descend upon us, by Christmas the earth here in the midwest is often covered with ice and snow. The first weeks in January usher in the more frigid days and weeks of winter engulfing us in cold winds, snow and ice. Yet, these are three great holidays to lift our spirits and give to us a new outlook on life.

Thanksgiving Day, it seems to me as I look back over the years, has lost a lot of its original significance. Those first immigrants to the shores of what would eventually become the US had undergone tremendous hardships. They faced a new environment, different peoples, uncertainty, as well as suffering, illness, death and loneliness. Yet they realized they had a need to show their gratitude for their new life. As history tells us, they had a party, a gathering of their own group and their new Indian friends, to give thanks. There was food and merriment, a time for gratitude.

How different Thanksgiving Day is now. Families are scattered afar. Many family units no longer exist. The sense of the original meaning of the day is lost in self-enjoyment and a football game. The diversity of family living has destroyed the beauty of "over the river and through the woods to grandmother's house we go." Besides, grandmother might not be home. She may be at a casino or a football game instead.

Let's bring back the "thanks" in Thanksgiving Day, for we do have so much for which to be thankful. I know I do: the guidance by parents and teachers during childhood, the opportunity for an excellent education, the abilities to practice medicine and the gift of family and friends. What more could one ask?

Then comes the holiday season. I respect all those who celebrate in various ways (or not celebrate) this time of the year as I do. For me, Christmas is another day of gratitude, for in my life the event of more than two thousand years ago, and all the meaning it holds has had much meaning to me. Numerous happenings fell upon me during the Christmas holidays: during World War II I reported for active duty on the day after Christmas, during the Korean Conflict I missed Christmas Day as we crossed the international date line on our way to Japan, and then best of all Christmas Day is our wedding anniversary (53 years this year).

We should vow to face 1998 with vigor and increased love for our fellows, to provide medical care with more compassion and less concern for material gains.



MARION ALBERTS, MD

(continued)

By tradition the season is one for gift giving and receiving. Truly, we have received gifts in abundance, but the beautifully wrapped gifts are only a token; it is not the gift that counts, it's the thoughts and love that went into it. So, again, let us put the real meaning into this day, this season, to reflect upon our blessings and the love that surrounds us. Above all, do your part in providing love, security and hope to those less fortunate than us.

Then in another week comes New Year's Day . . . more parties, sometimes too much frivolity and of course football games. By this time I do hope my readers do not entertain the idea that I am downgrading football. After all, having been born, raised and educated in the state immediately west of Iowa, I'm still a Cornhusker.

Again, put New Year's Day in a perspective of renewal for the following months. Though the frigid winter winds chill our bodies, let our hearts be warm. We should vow to face 1998 with vigor and increased love for our fellows, to provide medical care with more compassion and less concern for material gains. Our world will be better for all as we help preserve health and render aid and hope to the ill and disabled. As citizens we must have more awareness and compassion for the homeless, the hungry, the ill-clothed, the victims of abuse and crime, that peace can be universal in our hearts and our environment. IM

Another chapter completed

How does one close a great chapter in his life? Nearly 10 years ago I retired from my practice of pediatrics and faced that closure. Now I close another as scientific editor of *Iowa Medicine*. As announced on page 344, the decision has been made to discontinue scientific articles as a part of *Iowa Medicine*. I was honored in 1971 when the late Donald Taylor asked me to succeed Dr. Dennis Kelly as scientific editor, the sixth in a succession of editors since 1911.

During my tenure many changes have been made in our journal. There have been several changes made in the format to conform with changing patterns in state medical journal objectives. Several of the changes have resulted in the journal receiving national awards. *Iowa Medicine* stands tall among the medical journals of other state medical societies.

It has been a pleasure to work with very fine staff persons. Ed Hamilton, Polly Lynch, Don Neumann, Tina Preftakes, Jane Nieland, Chris McMahon and Bev Corron come to mind, as well as the officers and executive staff of the society. Furthermore, I value great friendships with editors of other state medical journals.

I sincerely hope my efforts have been such as to leave a mark on medical journalism in Iowa. It has been a joy to present my thoughts through the past nearly 27 years.

My thanks to all for your support and the kind expressions directed to me during this chapter in my life.—*MEA*

Baltimore

Learned and unlearned in the past year

The New Year approaches. What have I learned in the year that is concluding? A deceptively straightforward question. Unlike an investment account, there is accessible tally of knowledge or skill that I possessed on December 31, 1996 to be compared with a tally one year later. And fortunately there is no appraisal of what has been unlearned, facts stricken from the memory bank.

I reflected on varied developments, seeking contrasts in the immense realm of scientific medicine and its practice. Three issues emerged as contenders: the evolution in the management of HIV infection; the sobering influence of for-profit health care, and the occurrence of a milestone in American society's commitment to the health care of children.

The year past has been tumultuous in HIV management. Early reports of the success of multidrug protocols in altering the natural history of infection have been tempered by more recent studies suggesting that success may not be long-lived. The virus, it seems is adapting to the challenge of the toxins. Viruses do not exit this world easily, as every medical student learns in microbiology. Our best hope may be a familiar friend, a live attenuated virus that can potentially protect us from the natural culprit. It seems much of medicine can be learned from this tragedy.

Also remarkable during 1996 is the change in fortune of Wall Street corporate medicine. Not many observers would have predicted the turn-of-events for Columbia/HCA during recent months. An apparent obsession with the bottom line has led to interim disarray within this powerhouse corporation. Have we learned the need for profit growth by investors induces otherwise rational managers to commit crimes? Could health care adventures in excessive profit-seeking restore the altruism that has been all but abandoned in some sectors?

Finally, we have learned that societal commitment to the financing of health care perserveres, as evidenced by the enactment of Title XXI of the Social Security Act—the State Child Health Insurance Program. Approximately $24 billion is authorized over the next five years to insure children whose family income is below 200% of the federal poverty level. That amount translates into about $33 million federal dollars for Iowa annually, to fund care for an estimated 67,000 children from birth through 18 years of age in our state.

Approximately $24 billion is authorized over the next five years to insure children whose family income is below 200% of the federal poverty level.

That last thought accentuates this season of good will and portends a happier New Year for thousands of Iowa families and their physicians. IM

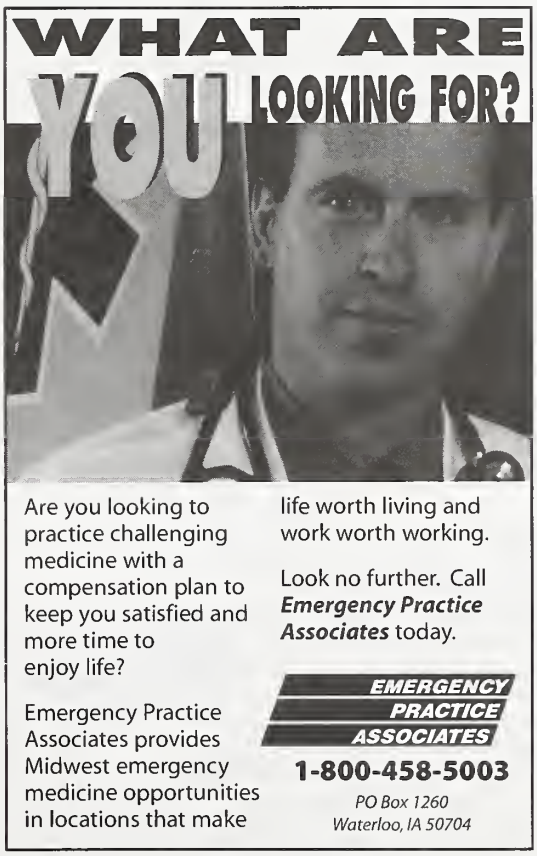


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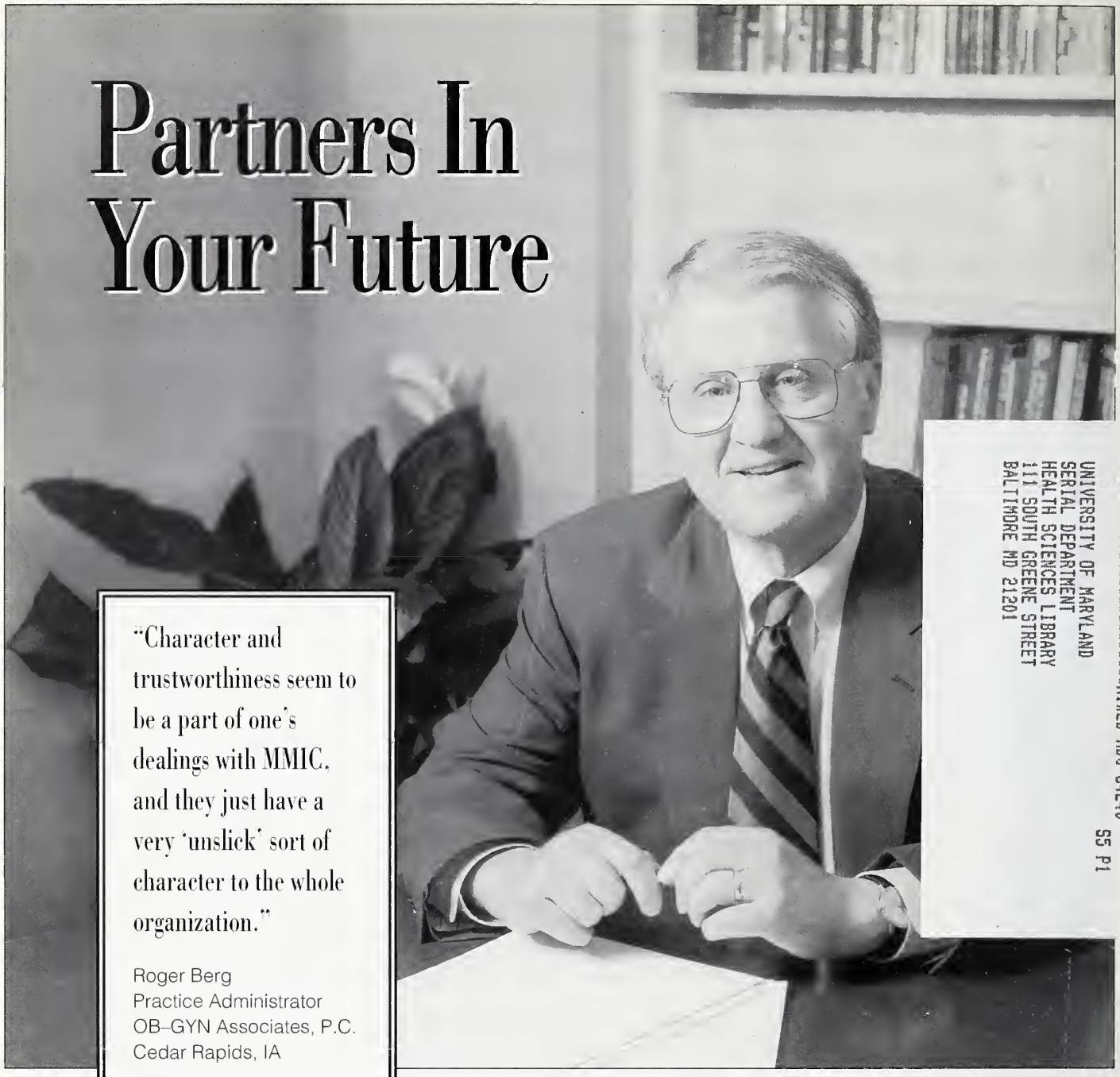
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